STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2045	A. BUILDING: _____ B. WING _____	C 10/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEEHIVE HOMES OF RIO RANCHO I	204 SILENT SPRING ROAD RIO RANCHO, NM 87124

(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 The following deficiencies were cited during a Complaint survey completed on 10/28/25 for the state requirements of NMAC 8.370.14, Regulations for Assisted Living for Adults. Census: [redacted] Complaint Intake # NM[redacted] was investigated and deficiencies were cited. Complaint Intake # NM[redacted] was investigated and deficiencies were not cited. Complaint Intake # NM[redacted] was investigated and deficiencies were cited.	8 000		
8 025	8 NMAC 370.14.25 Resident Evaluation A. A resident evaluation shall be completed by an appropriate staff member within 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 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.;	8 025		

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8 025	Continued From page 1 (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 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 months or when a significant change in health status occurs. [8.370.14.25 NMAC - N, 7/1/2024] This REQUIREMENT is not met as evidenced by: 8.370.14.25 C (17) Based on record review and interview, the facility failed to ensure for 1 (R #2) of 3 (R #'s 1 through 3) of residents reviewed that the evaluation appropriately documented wandering behaviors	8 025	8.025 Effective immediately, the House Manager and Administrator will audit all resident evaluations for wandering and correct scoring. Any discrepancies will be corrected and service plans will be updated. RN will review evaluations within 14 days to ensure accuracy. Any incident of exit seeking or elopement will trigger a new evaluation to be completed and ISP will be updated by House Manager. Administrator will be notified immediately of exit seeking or elopement. All interventions in place (fence corrections, window alarms, scheduled checks) are now documented in the resident's record Administrator will conduct monthly evaluation and service plan audits for 90 days to ensure compliance.	12/3/25

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8 025	Continued From page 2	8 025		

that address appropriate level of care and interventions implemented by the facility to decrease the resident's elopement risk.

This deficient practice could likely cause harm to residents if staff are unaware of their history of wandering behaviors and interventions put in place to safeguard the resident from elopement.

The findings are:

A. On 10/21/25 at 10:20 am, during an interview with R #2's Power of Attorney (POA), the POA stated R #2 eloped from the facility two times since [redacted] admission (date of admission [redacted] The first incident occurred on [redacted] The second occurred on [redacted]

B. Record review of R #2's face sheet revealed R #2's admission date was [redacted] with diagnoses of [redacted]

C. Record review of R #2's Assistance with Daily Living document (ADL) dated [redacted] revealed R #2 was at risk of wandering, both inside and outside. R #2 was ordered to have hourly checks.

D. Record Review of [name of local police department's] Police Report dated [redacted] by [name of officer], stated R #2 was reported missing. R #2 was last seen at the 4:00 am bed

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8 025	Continued From page 3	8 025		

check and had eloped from [Name of Facility]. R #2 escaped through a window and tripped the window alarm.

E. Record review of R #2's initial evaluation dated [redacted], revealed R #2 was at risk of elopement. On the [redacted] evaluation there was a point scale, adding up to the residents "level of care" score determination. 4 points were added for R #4's wandering risk inside and 8 points were added for wandering outside. The total of R #2's wandering risk score was 12.

F. Record review of R #2's internal incident report (facility-created incident report) dated [redacted] at 8:00 am, revealed R #2 had another elopement from the facility. R #2 was last seen at 7:20 am. It was determined that R #2 climbed the fence in the back exercise area and left the property.

G. Record review of R #2's shift change notes of the second elopement, dated [redacted] revealed an entry which stated R #2 had "jumped the fence" in the morning of [redacted] and was found on [Name of Street] and brought back to the facility.

H. Record review of R #2's evaluation dated [redacted] revealed R #2 was at risk of elopement. On the [redacted] evaluation the point scale, adding up to the residents "level of care" score determination had the previous 4 points added for R #4's wandering risk inside but 8 points were not added for R #2's history of wandering outside. As a result, the total of R #2's wandering risk score was reduced from 12 to 4, signaling the resident was less of a wandering risk.

I. On 10/23/25 at 09:50 am, during an interview, Administrator #2 - former (Admin 2) confirmed

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8 025	Continued From page 4 she was aware of the elopement incidents dated [redacted] and [redacted]. 1. She stated R #2 was re-evaluated after the elopements that occurred on [redacted] and [redacted] and the re-assessment meetings were completed by the house manager 2. 2. She stated the documentation written in the evaluation dated [redacted] revealed interventions implemented for each elopement, such as the replaced slats to the back fence. J. On 10/23/25 at 10:15 am, during an interview with the administrator, she stated she read through R #2's facility files including R #2's web-based medical files and she found no documentation of any interventions implemented by the facility, written in the evaluation dated [redacted] post elopements. K. On 11/19/25 at 10:25 am, during an interview, the administrator confirmed the resident evaluation dated [redacted] did not properly document the resident's residents "level of care" score determination with risk of wandering outside after the incidents of elopement on [redacted] and [redacted]. She also confirmed the risk score was incorrectly tabulated by excluding R #2's risk of wandering outside.	8 025		
8 032	8 NMAC 370.14.32 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 8.370.9 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	8 032		

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8 032	Continued From page 5 staff to the licensing authority complaint hotline within 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 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 8.370.9 NMAC; and (3) plans for further actions in response to the incident. [8.370.14.32 NMAC - N, 7/1/2024] This REQUIREMENT is not met as evidenced by: 8.370.14.32 A (1) B REPORTING OF INCIDENTS: A. The facility shall ensure (to make certain that something shall occur or be the case) that all suspected cases or known incidents of resident abuse, neglect or exploitation are reported in accordance with 8.370.9 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	8 032	8.032 Effective immediately, all staff will be retrained on incident reporting procedures including the requirement to notify the Licensing Authority within 24 hours of discovery and submit a 5-day follow-up report. Any incident involving suspected abuse, neglect, or exploitation will be reported without delay, prior to conducting an internal investigation. The Administrator is responsible for reporting incidents to the Licensing Authority and completing a 5 day follow up. An incident report binder will be maintained for all incident reports reported to the Licensing Authority. The Administrator will review the binder weekly for the next 90 days to ensure compliance.	12/3/25

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8 032	Continued From page 6 within twenty-four (24) hours or by the next business day, if it is a weekend or a holiday. (3) All licensed health care facilities shall ensure that the reporter with direct knowledge of an incident has immediate access to the bureau incident report form to allow the reporter to respond to, report, and document incidents in a timely and accurate manner. 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. Based on record review and interview, facility failed to ensure for 1 (R #2) of [redacted] (R #'s 1 through [redacted] of the Memory Care (MC) residents that incidents were reported within twenty-four (24) hours and an investigation was conducted within five (5) business days and reported to the Licensing Authority (LA). These deficient practices could impede (delay or prevent) regulatory oversight and hinder (create difficulties resulting in delay) the identification of care trends or patterns that may affect resident safety and health outcomes. The findings are: A. Record review of R #2 face sheet revealed R #2's admission date was [redacted] with of [redacted]	8 032		

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[redacted]

B. Record review of the [Name of city] Police Department's Report for R #2's elopement on [redacted] revealed R #2 was reported missing by facility staff. R #2 was last seen at the [redacted] bed check and had eloped from [Name of Facility], escaping through a window and thereby tripping the window alarm. R #2 was found by police officers confused and cold. The police officer placed [redacted] in his police car until medics arrived. The medics checked R #2 for injuries and determined that R #2 had not sustained injuries.

C. On 10/21/25 at 10:20 am, during an interview with R #2's Power of Attorney (POA), he stated R #2 eloped from the facility two times. The first incident occurred on [redacted]. The second occurred on [redacted] The POA stated his concerns about R #2's history of elopements from the family home was discussed with the facility administrator upon admission.

D. On 10/23/25 at 11:10 am, during an interview with [Name of city] police dispatch, she stated the elopement incident on [redacted] was reported to police and two officers were dispatched to look for a [redacted] (R #2) missing from [Name of facility]. R #2 was located by police officers on [Name of street] and returned to the facility staff. R #2 sustained no injuries.

E. Record review of the facility's incident report log revealed no entry regarding R #2's [redacted]

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8 032	Continued From page 8 elopement. F. Record review of the State licensing Authority website revealed there was no copy of an incident investigation report or five(5) day follow up submitted to the state licensing authority. G. On 10/22/25 at 1:50 pm during an interview, Administrator (Admin) #2 confirmed R #2 had two elopements dated [redacted] and [redacted] H. On 10/23/25 at 9:50 am, during an interview, Admin #2 confirmed the following information regarding the R #2's elopements: 1. She confirmed R #2's elopement dated [redacted], and R #2 went out [redacted] bedroom's southeast facing window, in [redacted] and left the facility. 2. She confirmed the elopement dated [redacted], and R #2 jumped over the back fence and left the facility. Admin #2 stated there were incident reports completed and documented in the facility incident report (IR) folders, completed by the house manager 2 (HM2). I. Record review of the facility's incident report log revealed the facility conducted an internal investigation, signed by Admin 2 on [redacted] which internally investigated R #2's [redacted] elopement and that the investigation was completed within five (5) business days; however, no copy of the incident report or the five (5) day follow up was submitted to the state licensing authority. J. On 10/23/25 at 3:30 pm, during an interview, the administrator confirmed R #2's elopement dated [redacted] did not have an investigation conducted within five (5) business days of the incident and the elopement was not reported to	8 032		

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8 032	Continued From page 9 the state licensing authority. K. On 10/23/25 at 3:30 pm, during an interview, the administrator confirmed R #2's elopement dated [redacted] was internally investigated within twenty-four (24) hours; however, the [redacted] elopement was not reported to the state licensing authority or five(5) day follow up submitted to the state licensing authority.	8 032		
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 (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	8 033		

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8 033	Continued From page 10 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; (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;	8 033		

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8 033	Continued From page 11 (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; 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	8 033		

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8 033	Continued From page 12 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 11 (a) Based on record review and interview, the facility failed to ensure for 1 (R [redacted] of 1 (R [redacted]) residents that their scheduled medications and PRN [pro re nata (as needed)] [redacted] medications were administered as ordered by the physician and the were free from misappropriation of medications (illegal or unlawful conversion of a drug to one's own use or to the use of another). These deficient practices resulted in the residents not receiving their [redacted] medications as ordered by their physician to [redacted] which was purchased by their medical plan. The findings are: A. Record review of R [redacted] Physician Orders dated 04/02/24 revealed [redacted]	8 033	8.033 The Administrator and House Manager are responsible for ensuring compliance with resident rights and proper medication administration. The Administrator will review narcotic counts weekly for the next 90 days. The Administrator and House manager will review MARS and narcotic logs weekly to confirm accuracy and ensure PRN medications are being given.	12/3/25

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(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
8 033	Continued From page 13 B. Record review of R[redacted] Individual Service Plan (ISP) dated 04/28/24 revealed [redacted] was to be administered when the resident was [redacted] C. Record review of R[redacted] Medication Administration Record (MAR) dated 04/2024 through 07/2025 revealed no documentation that [redacted] was ever administered during this timeframe. D. Record review of R[redacted] shift change notes revealed the following: 1. On 04/07/24 R[redacted] had [redacted] 2. On 07/15/24, R[redacted] woke up [redacted] was [redacted] E. On 10/22/25 at 11:00 AM, during an interview, the Pharmacist confirmed two blister packs (medication packaging that organizes individual doses of medication into pre-sealed compartments) with 30 tablets each of [redacted] were filled in April 2024 and May 2024, totaling 60 tablets. F. Record review of the facility's Narcotic Log dated 04/11/24 revealed R[redacted] had 30 [redacted] and was logged by House Manager #1. G. Record review of the Record of Destruction of Narcotic/Controlled Substances revealed on 07/17/25 R[redacted] was recorded as destroyed with only 29 tablets. H. On 10/23/25 and 2:41 PM, during an interview, the Administrator confirmed R[redacted] did not receive the [redacted] as ordered by the physician, the Narcotic Count Record and the Record of	8 033		

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8 033	Continued From page 14 Destruction were inaccurate with only 29 [redacted] tablets accounted for.	8 033		
8 034	8 NMAC 370.14.34 Custodial Drug Permits A facility with two or more residents that is licensed pursuant to this rule and that assists with self-administration or safeguards medications for residents shall have a current custodial drug permit issued by the state board of pharmacy. A. Procurement, labeling and storage: The facility shall provide assistance to the resident in obtaining the necessary medications, treatment and medical supplies as identified in the ISP. The facility shall procure, label and store medications for residents who require assistance with self-administration of medication in compliance with state and federal laws. (1) All medications, including non-prescription 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	8 034		

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8 034	Continued From page 15 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 pharmacy. (7) Medical gases (oxygen) and equipment used for the administration of inhalation therapy and for resuscitative purposes shall comply with the national fire protection association (NFPA) 99. (8) A proof of use record shall be maintained separately for each schedule II through IV drug (controlled substances). The proof of use sheet shall document: (a) the type and strength of the schedule II through IV drugs; (b) the date and time staff assisted with self-administration; (c) the resident's name; (d) the prescriber's name; (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,	8 034		

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8 034	Continued From page 16 but at least quarterly/every three months, to determine that all medications and records are accurate and current. All irregularities shall be reported to the administrator of the facility and these irregularities shall be resolved by the administrator within 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 8.370.14 NMAC. [8.370.14.34 NMAC - N, 7/1/2024] This REQUIREMENT is not met as evidenced by: 8.370.14.34 A 8 (g) 10 B (2) Based on record review and interview, the facility failed to ensure for 2 (R [redacted] and R [redacted] of 2 (R [redacted] and R [redacted] residents that the Narcotic Count Records (a document used in healthcare settings to track the inventory of controlled substances to ensure accurate tracking, management, and accountability of these medications to prevent misuse and unauthorized access) and the medication destruction records were accurate and that the facility maintained proper records of receipt and disposition of all drugs in sufficient detail to enable an accurate reconciliation. These deficient practices could likely result in a	8 034	8.034 Effective immediately, narcotic sheets have been reinstated and are maintained in narcotic log book. All narcotics are counted and signed by two staff at every shift change. Discontinued or expired mediations are separated, documented, and secured until destruction from the consulting pharmacist. The House Manager and Adminisrator are responsible for maintaining proper narcotic documentation with oversight from the consulting pharmacist. The Administrator and House Manager will review narcotic logs weekily for accuracy. The Consulting pharmacist will conduct a full review of controlled substance records quarterly, and findings will be submitted in writing to the Administrator. Discrepencies will be addressed immediatelly.	12/3/25

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8 034	Continued From page 17 high risk of drug diversion that could impact residents by leading to inadequate pain management and medication errors. The findings are: R [redacted] A. Record review of R [redacted] physician order dated 04/02/24 revealed [redacted] B. Record review R [redacted] Medication Administration Record (MAR) dated 04/2024 through 07/2025 revealed no [redacted] was ever marked as administered. C. On 10/22/25 at 11:00 AM, during an interview, the Pharmacist confirmed two (2) blister packs (medication packaging that organizes individual doses of medication into pre-sealed compartments) with 30 tablets of [redacted] each were filled; once in April 2024 and once in May 2024, totaling 60 tablets. D. Record review of R [redacted] Narcotic Count Record revealed 29 tablets were documented as received by the facility and none marked on the MARs dated 04/2024 through 09/2024 as administered. E. Record review of the facility's Narcotic Log revealed on 04/11/24, R [redacted] had 30 [redacted] tablets that was assigned to Narcotic Count sheet	8 034		

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8 034	Continued From page 18 #42 by House Manager #1. Narcotic Count Record #42 is not in facility records. F. Record review of the facility's Record of Medication Received revealed no records of medications received by the facility for January 2024 through May 27, 2024. G. Record review of the facility's Medication Destruction Log revealed on 07/17/24 only 29 tablets of [redacted] were destroyed. H. On 10/23/25 at 2:41 PM, during an interview, the Administrator confirmed there were only 29 of the 60 [redacted] tablets accounted for. R [redacted] I. Record review of R [redacted] physician order dated 08/04/24 revealed the following: 1. [redacted] 2. Discontinue order for [redacted] J. Record review of R [redacted] physician orders revealed no order for the [redacted] tablet [redacted] and start date. K. Record review of a physician's order dated 08/12/24 revealed: 1. [redacted] tablet, [redacted] for [redacted] (1 tablet three times a day). 2. Discontinue [redacted] oral tablet, [redacted] L. Record review of a physician's order dated 09/09/24 revealed:	8 034		

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8 034	Continued From page 19 1. [redacted]) to start on 09/09/24. 2. [redacted] oral [redacted] 3. Discontinue [redacted] oral tablet 1 [redacted] daily for [redacted] M. Record review of a physician's order dated 09/13/24 revealed: 1. [redacted] (every 2 hours). 2. Discontinued [redacted] every 4 hours. Findings related to [redacted] N. Record review of the facility's Narcotic Control Log revealed on 08/06/24, [redacted] was documented as received by the facility with a quantity of 30 and assigned to Narcotic Count Record sheet #72. O. Record review of the facility's Narcotic Count Records and the Narcotic Count Records revealed no sheet #72 for the [redacted] quantity 30. Findings related to [redacted] P. Record review of R #5's physician orders revealed no order for the [redacted] Q 3 hours (every 3 hours) as needed but is on the MAR. Q. Record review of R [redacted] Narcotic Count Records revealed: 1. No Narcotic Record for [redacted] l every 2 hours as needed for	8 034		

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8 034	Continued From page 20 [redacted] 2. It was documented on the September 2024 MAR on 09/05/24 and 09/09/24 by DCS #21, and on 09/06/24 by DCS #9. R. Record review of the Narcotic Count Record #89, [redacted]e, [redacted] as needed (PRN) revealed: 1. On 09/14/24, the PRN Narcotic Count Record was documented as administered at 6:10 AM by DCS #14, 8:06 AM, 9:42 AM, 11:32 AM, 2:03 PM, 3:54 PM, and 5:30 PM by DCS #13, and 7:38 PM and 10:04 PM by DCS #14 which is not 4 hours apart. 2. On 09/15/24, the PRN Narcotic Count Record was documented as administred at 12:12 AM, 2:15 AM, 4:10 AM, and 6:03 AM by DCS #14, 8:31 AM, 9:39 AM, 11:38 AM, 1:44 PM, 3: 28 PM, and 5:39 PM by DCS #13, and 8:18 PM, and 10:13 PM by DCS #14 which is not 4 hours apart. Findings related to [redacted] S. Record review of Narcotic Count Record for [redacted] a day for pain, start date: 08/06/24 End date: 08/12/24 revealed: 1. Medication fill date: 08/05/24 2. Narcotic Count Record sheet #72, 30 tablets documented as received in 08/06/24 by House Manager 1. 3. On 08/10/24, the ending count was 16. On 08/11/24, the ending count was 14 and should have been 15. This demonstrates the Narcotic Count Record is incorrect. 4. On 08/11/24, on the Narcotic Count Record, two doses were marked as administered at 8:29 AM and 8:26 PM. On the August 2024 MAR, only the 2:00 PM dose was marked as administered by DCS #12.	8 034		

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8 034	Continued From page 21 5. The physician orders for the [redacted] times a day for [redacted], stop date was 08/12/24 but was being documented on the August 2024 MAR under the [redacted] times a day section until 08/15/24. T. Record review of Narcotic Count Record sheet #75 revealed 08/31/24 was documented on the count sheet twice by DCS #13 and once on Narcotic Count Record sheet #83 by DCS 17. U. Record review of Narcotic Count Record sheet #80 revealed: 1. Medication was documented on 08/29/24 as received by House Manager 1 with 16 tablets. 2. [redacted] times a day for [redacted]. The [redacted] was discontinued on 08/12/24. 3. The Narcotic Count Record was documented as administered on 08/30/24 at 7:27 AM and 01:30 PM by DCS #9. It was documented on the [redacted] times a day section of the August 2024 MAR. 4. On 08/31/24, the documentation was crossed out on sheet #80 and re-written on Narcotic Count Record sheet # 83 by DCS #17, but the remaining amount of medications continued to decrease which demontrates an inaccurate narcotic count. 5. A total of 4 doses were marked as administer on sheet #80, and only 10 tablets remaining when there should be 12 which demontrates an inaccurate narcotic count. V. Record review of Narcotic Count Records for [redacted] times a day for [redacted] 1. 09/01/24 at 8:51 AM was documented as administered on Narcotic Count Record sheet #75 by DCS #14.	8 034		

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8 034	Continued From page 22 2. 09/01/24 at 2:38 PM was documented as administered on Narcotic Count Record sheet #80, the [redacted] count sheet, by DCS #14. 3. 09/01/24 at 9:06 PM was documented as administered on Narcotic Count Record sheet #83 by DCS #17. 4. 09/02/24 was documented twice on sheet #83 by DCS 14 at 8:19 AM and 2:30 PM. 5. 09/02/24 was documented by DCS #13 at 8:35 PM and then crossed out, but the remaining count still went down and was documented as administered on the September 2024 MAR with no exception to explain. On 10/22/25 at 2:45 PM, during an interview, Hopsice Nurse 2 confirmed only one (1) narcotic count record sheet should be used for each narcotic medication. Findings related to [redacted] W. Record review of R[redacted] physician orders revealed no order for the [redacted] but is on the MAR. Start date: 07/17/24, Stop date: 08/05/24. X. Record review of the Record of Medication received revealed on 07/19/24 thirty (30) [redacted] tablets were documented as received by DCS #13. Y. Record review of the Medication Control Log revealed on 07/22/24 R[redacted] was documented by House Manager 1 on 07/22/24 and was listed as being on Narcotic Count Record sheet #63. Z. Record review of Narcotic Count Records revealed no count record for the [redacted]	8 034		

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8 034	Continued From page 23 AA. Record review of R[redacted] July 2024 through September 2024 MAR revealed on 07/25/24, [redacted] was documented as administered twice, once by DCS #16 and and once by House Manager 1. BB. Record review of the Records of Destruction revealed no record of the remaining 28 [redacted] being destroyed. CC. On 11/07/25 at 3:16 PM, during an interview, the Administrator confirmed there are multiple documentation errors that can result in accurate narcotic count, and there is no record of destruction for R[redacted].	8 034		
8 035	8 NMAC 370.14.35 Medication 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	8 035		

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8 035	Continued From page 24 written consent for assistance with self-administration of medications. All staff that assist with self-administration of medications shall have successfully completed a state approved assistance with self-administration of medication training program or be licensed or certified by the state board of nursing. C. PRN (pro re nada) medication: (1) Physician or physician extender's orders for PRN medications shall clearly indicate the circumstances in which they are to be used, the number of doses that may be given in a 24-hour period and indicate under what circumstances the primary care practitioner (PCP) is to be notified. (2) The utilization of PRN medications shall be reviewed routinely. Frequent or escalating use of PRN medications shall be reported to the PCP. D. Only a licensed nurse (RN or LPN) shall administer any medications or conduct any invasive procedures provided by the following routes: intravenous (IV), subcutaneous (SQ), intramuscular (IM), vaginal or rectal. Only a licensed nurse shall administer non-premixed nebulizer treatments. E. The facility shall have medication reference material that contains information relating to drug interactions and side effects on the premises. Staff that assist in the self-administration of medications shall know interactions or possible side effects that might occur. F. Medications prescribed for one resident shall not be used for another resident. 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	8 035		

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8 035	Continued From page 25 administered to the resident by licensed or certified staff. The information in the MAR shall include: (1) the resident's name; (2) any known allergies to medication that the resident has; (3) the name of the resident's PCP or the prescriber of the medication; (4) the diagnosis or reason for the medication; (5) the name of the medication, including the drug product brand name and the generic name; (6) notation if the medication is a schedule II-IV drug; (7) the dosage of the medication; (8) the strength of the medication; (9) the frequency or how often the medication is to be taken or given; (10) the route of delivery for the medication (mouth, eye, ear, other); (11) the method of delivery for the medication (pills, drops, IM injection, other); (12) the date that the medication was started or discontinued; (13) any change in the medication order; (14) pre-medication information (i.e., pulse, respiration, blood pressure, blood sugar) as required by the medication order; (15) the date and time that the medication is self-administered, administered with assistance or is administered; (16) the initials and signature of the person assisting with or administering the medication; (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	8 035		

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8 035	Continued From page 26 without specific orders from the primary care physician. I. If a resident refuses to take a prescribed medication, it shall be documented and the facility shall report it to the prescriber. J. A suspected adverse reaction to a medication shall be documented on the MAR and reported immediately to the PCP and the resident's surrogate decision maker. If applicable, emergency medical treatment shall be arranged. Documentation of the event shall be kept in the resident's record. K. Prescription medication, other than blister packs and unit dose containers, shall be kept in the original container with a pharmacy label that includes the following: (1) the resident's name; (2) the name of the medication; (3) the date that the prescription was issued; (4) the prescribed dosage and the instructions for administration of the medication; and (5) the name and title of the prescriber. L. Any medication that is removed from the pharmacy container or blister pack shall be given immediately and documented by the staff that assisted with the medication delivery. M. The facility shall report all medication errors to the physician, documentation of medication errors and the prescriber's response shall be kept in the resident's record. N. The facility shall develop and follow a written policy for unused, outdated, or recalled medications kept in the facility in accordance with 16.19.11.10 NMAC. [8.370.14.35 NMAC - N, 7/1/2024] This REQUIREMENT is not met as evidenced by: 8.370.14.35 G L	8 035		

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8 035	Continued From page 27 Based on record review and interview, the facility failed to ensure for 2 (R #'s [redacted] and [redacted] of 2 (R #'s [redacted] and [redacted] residents whose Medication Administration Record (MAR) was reviewed for compliance that medications were properly documented as administered on the Medication Administration Record (MAR). This deficient practice has the potential to cause harm to the residents listed on the census provided by the Administrator on 10/20/25 if the medication administration is not accurately documented. The findings are: A. Record review of R [redacted] physician order dated 08/04/24 revealed the following: 1. [redacted] 2. Discontinue order for [redacted] B. Record review of R [redacted] physician orders revealed no order for the start of [redacted] BID and start date. The medication was listed on the July 2024 MAR with a start date of 07/25/24 and end date of 08/05/24. C. Record review of R [redacted] physician order dated 08/12/24 revealed the following: 1. [redacted] times a day). 2. Discontinue [redacted]. D. Record review of R [redacted] physician order dated 09/09/24 revealed the following:	8 035	8.035 Effective immediately all medications will be reconciled by providers and MARS will be audited to ensure accuracy. All PRN medications will be reviewed to ensure instructions and limitations are clearly written. All staff who assist with medications have taken the New Mexico approved Assistance with Self Administration training. All medication errors will be documented on medication error form and reported to provider. All medication error reports will be printed and put in medication error binder House Manager is responsible for reporting medication errors and notifying Administrator Administrator will audit medication error binder weekly	12/3/25

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8 035	Continued From page 28 1. [redacted] start on 09/09/24. 2. [redacted] 3. Discontinue [redacted] E. Record review of R[redacted] physician order dated 09/13/24 revealed the following: 1. [redacted] 2. Discontinued [redacted] F. Record review of R[redacted] physician orders revealed no order for the [redacted] but is on the July, August, and September 2024 MAR. Findings related to the Narcotic Count Records for the scheduled (8:00 PM) [redacted]: G. Record review of R[redacted] July 2024 MAR revealed: 1. On 07/03/24, the [redacted] was documented on the MAR as administered by DCS #13 but was not documented on the Narcotic Count Record which resulted in an inacurate narcotic count record. 2. On 07/06/24, the [redacted] was documented on the MAR as administered by DCS #14 but was not documented on the Narcotic Count Record which resulted in an inacurate narcotic count record. 3. On 07/08/24, the [redacted] was documented on the MAR as administered by DCS #13 but was not documented on the Narcotic Count Record which resulted in an	8 035		

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8 035	Continued From page 29 inacurate narcotic count record. 4. On 07/15/24, the [redacted] was documented on the MAR as administered by DCS #5 but was not documented on the Narcotic Count Record which resulted in an inacurate narcotic count record. 5. On dates 07/16/24, 07/17/24, and 07/18/24, the [redacted] was documented on the MAR as administered by DCS #13 but was not documented on the Narcotic Count Record which could result in an inacurate narcotic count record. H. Record review of R[redacted] August 2024 MAR revealed on 08/13/24, the [redacted] was documented on the MAR as administered by DCS #12 but was not documented on the Narcotic Count Record which could result in an inacurate narcotic count record. I. Record review of R[redacted] September 2024 MAR revealed: 1. On 09/07/24, the [redacted] was documented on the MAR as administered by DCS #17 but was not documented on the Narcotic Count Record which resulted in an inacurate narcotic count record. 2. On 09/09/24, the [redacted] was documented on the MAR as administered by DCS #14 but was not documented on the Narcotic Count Record which resulted in an inacurate narcotic count record. 3. On 09/12/24, the [redacted] was documented on the MAR as administered by DCS #13 but was not documented on the Narcotic Count Record which resulted in an inacurate narcotic count record. 4. On 09/13/24, the [redacted] was documented on the MAR as administered by DCS #14 but was not documented on the	8 035		

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8 035	Continued From page 30 Narcotic Count Record which resulted in an inacurate narcotic count record. J. Record review of R[redacted] Narcotic Record on dates 09/10/24 and 09/13/24, [redacted] marked as administered. Nothing logged on the MAR for those dates which resulted in an inacurate narcotic count record. Findings related to the Narcotic Count Records for the PRN (as needed)[redacted] K. Record review of R[redacted] July 2024 MAR revealed: 1. On 07/07/24, no documentation of medication administered on the MAR but on the Narcotic Count Record it was documented as administered by DCS #13 which resulted in an inacurate narcotic count record. 2. On 07/15/24, no documentation of the medication administered on the MAR but on the Narcotic Count Record it was documented as administered by DCS #5 which resulted in an inacurate narcotic count record. 3. On 07/16/24 and 07/17/24, no documentation of the medication administered on the MAR but on the Narcotic Count Record it was documented as administered by DCS #13 which resulted in an inacurate narcotic count record.. 4. On 07/18/24, the medication was documented as administered on the MAR once but on the Narcotic Count Record it was documented twice as administered by DCS #13 which resulted in an inacurate narcotic count record. L. Record review of R[redacted] September 2024 MAR for[redacted] revealed:	8 035		

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8 035	Continued From page 31 1. On 09/12/24, no documentation as administered on the MAR but on the Narcotic Count Record it was documented as administered by DCS #13 which resulted in an inacurate narcotic count record. 2. On 09/13/24, no documentation as administered on the MAR but on the Narcotic Count Record it was documented as administered by DCS #14 which resulted in an inacurate narcotic count record. Findings related to the Narcotic Count Records for the PRN (as needed) [redacted] M. Record review of R[redacted] Narcotic Count Records revealed no Narcotic Record for [redacted] N. Record review of the Narcotic Count Record #89, [redacted] revealed: 1. On 09/14/24, the PRN Narcotic Count Record was documented on the MAR at 6:10 AM by DCS #14 and 8:06 AM, 9:42 AM, 11:32 AM, 2:03 PM, 3:54 PM, and 5:30 PM by DCS #13, and at 7:38 PM and 10:04 PM by DCS #14 which is not every 4 hours and demonstrates improper documentation and resulted in an inacurate narcotic count record. 2. On 09/15/24, the PRN Narcotic Count Record was documented on the MAR at 12:12 AM, 2:15 AM, 4:10 AM, and 6:03 AM by DCS #14, at 8:31 AM, 9:39 AM, 11:38 AM, 1:44 PM, 3: 28 PM, and 5:39 PM by DCS #13, and at 8:18 PM, and 10:13 PM by DCS #14, which is not every 4 hours which resulted in an inacurate narcotic count record. Findings related to the Narcotic Count Records	8 035		

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8 035	Continued From page 32 for the [redacted] O. Record review of R [redacted] August 2024 MAR for [redacted] start date: 08/06/24 End date: 08/12/24 revealed the stop date was 08/12/24 and was being documented on the August 2024 MAR under the [redacted] a day section until 08/15/24 which resulted in an inacurate narcotic count record. P. On 11/07/25 at 3:16 PM, the Administrator confirmed the multiple documentation errors that can result in accurate narcotic count.	8 035		
8 036	8 NMAC 370.14.36 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. (1) Meal service: The facility shall: (a) serve at least three meals or their equivalent each day at regular times with no more than 16 hours between the evening meal and morning meal with snacks freely available;	8 036		

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8 036	Continued From page 33 (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 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 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; (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	8 036		

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8 036	Continued From page 34 (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 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, 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	8 036		

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8 036	Continued From page 35	8 036		

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.

(1) The facility shall ensure that a minimum of a three calendar day supply of perishables and a five 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 degrees fahrenheit of the required temperature, located in the warmest section of the refrigerator and freezer and shall be accessible and easily read.

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8 036	Continued From page 36 (a) The temperature of the refrigerator shall be 35 - 41 degrees fahrenheit. (b) Freezer temperatures shall be maintained at zero 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 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 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. (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 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 41 degrees fahrenheit; (b) the temperature for all hot foods is maintained at 140 degrees fahrenheit; and (c) all displayed or transported food is protected from environmental contamination and	8 036		

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8 036	Continued From page 37 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. [8.370.14.36 NMAC - N, 7/1/2024] This REQUIREMENT is not met as evidenced by: 8.140.370.36 C (4) (5) Based on observation and interview, the facility failed to ensure the health and wellbeing of [redacted] (R #1 - R [redacted]) of 11 (R#1 - R[redacted] residents living in the facility, by not ensuring: 1. Cooks and food handlers wear hair nets or caps at all times when engaged in handling food, drink, utensils or equipment in accordance with the local health authority. 2. All garbage and kitchen refuse be kept in watertight containers with close fitting covers and disposed of daily in a safe and sanitary manner. These deficient practices could likely result in residents being at risk of food contamination due to garbage container not properly sealed and food	8 036	8.036 Effective immediately, all staff have been re-educated on importance of wearing hair nets when preparing or handling food. Effective immediately, all garbage cans have lids and staff have been trained to keep lids on trash cans at all times House Manager is responsible for ensuring compliance with hair nets and trash can lids.	10/23/25 10/23/25

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8 036	Continued From page 38 handling without a hair net or cap. The findings are: A. On 10/20/25, at 11:06 am, during an observation of the kitchen, the garbage container was not covered with a lid and Kitchen Worker was in the process of meal preparation without a hair net or cap. B. On 10/20/25 at 11:08 am, during an interview with the administrator 2, she confirmed (Kitchen Worker) was not wearing a hair net during meal preparation and the garbage can was left uncovered.	8 036		
8 038	8 NMAC 370.14.38 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	8 038		

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8 038	Continued From page 39 state environment department requirements, 11.5.2.9 NMAC. [8.370.14.38 NMAC - N, 7/1/2024] This REQUIREMENT is not met as evidenced by: 8.370.14.38 C Based on observation and interview, the facility failed to ensure poisonous or flammable chemicals were stored in a secured area and not in residential areas, food preparation or food storage areas. This deficient practice could likely result in residents becoming ill if they ingest (take food, drink, or another substance in the body by swallowing or absorbing it) or spill the chemicals. The findings are: A. On 10/20/25 at 12:42 pm, during an observation of the facility's kitchen, the cabinet directly below the sink was unsecured with the following chemicals inside: 1. One (1) bottle 3.78 quart germicidal bleach concentrate. 2. One (1) bottle 1 quart industrial degreaser concentrate. B. 10/20/25 at 12:42 pm, during an interview, the administrator confirmed the unsecured chemicals in the unsecured kitchen cabinet below the sink.	8 038	8.038 Effective immediately, all poisonous and flammable chemicals were moved to a secured and locked cabinet. Staff will be re-trained on proper storage of chemicals House Manager is responsible responsible for ensuring proper storage of chemicals Administrator will conduct weekly walk through to ensure chemicals are stored properly for the next 90 days	10/23/25 12/12/25
8 042	8 NMAC 370.14.42 Maintenance of Building and Grounds The building(s) shall be maintained in good repair	8 042		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2045	A. BUILDING: _____ B. WING _____	C 10/28/2025

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8 042	Continued From page 40 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. [8.370.14.42 NMAC - N, 7/1/2024] This REQUIREMENT is not met as evidenced by: 8.370.14.42 A Based on observation and interview, the facility failed to ensure the ceiling in the Southeast (SE) hallways had no penetrations/perforations (holes/gaps), and was maintained in good repair at all times. This deficient practice could likely result in the [redacted] residents listed on the census provided by the Administrator on 10/20/25 to be at risk of harm, injury, or death if there were a fire and it was not contained due to perforations (holes/gaps) in the ceilings. The findings are: A. On 10/20/25 at 11:06 AM, during an observation of the facility's grounds revealed a perforation in the ceiling where a camera previously was located in the SE hallways next to room 11. B. On 10/24/25 at 2:41 PM, during an interview, the Administrator confirmed the perforation in the	8 042	8.042 Effective immediately, Maintenance was notified of hole in ceiling and has since come out to repair. House Manager is responsible for walking through and checking home weekly for any repairs and logging repairs on maintenance log. Administrator will conduct weekly walk through and audit of maintenace log for the next 90 days	10/23/25

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8 042	Continued From page 41 ceiling where a camera previously was located in the SE hallway next to [redacted]	8 042		
8 063	8 NMAC 370.14.63 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 2A10BC fire extinguishers: (1) one extinguisher located in the kitchen or food preparation area; (2) one 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 50 feet. B. Fire extinguishers, alarm systems, automatic detection equipment and other firefighting equipment shall be properly maintained and inspected as recommended by the manufacturer, state fire marshal, or the local fire authority. [8.370.14.63 NMAC - N, 7/1/2024] This REQUIREMENT is not met as evidenced by: 8.370.14.63 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.	8 063	8.063 Effective immediately all fire extinguishers were checked and signed off on. The House Manager is responsible for ensuring fire extinguishers are checked monthly. Monthly fire drill log has section to document that fire extinguishers have been checked. House Manager will also take picture of tag, print, and put in fire drill book for the next 90 days. Administrator will audit tags and fire drill book for the next 90 days to ensure compliance.	10/23/25 12/3/25

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8 063	Continued From page 42 Based on observation and interview, the facility failed to ensure fire extinguishers were being inspected monthly as recommended by the manufacturer. This deficient practice could likely result in residents, 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 10/20/25 at 11:18 AM, during observation of the facility's fire extinguishers, four (4) fire extinguishers had not been inspected monthly as recommended by the manufacturer: 1. One (1) fire extinguisher located by room [redacted] in the Southeast (SE) hallway. The last documentation of the monthly inspection as being performed was on 04/04/25. 2. One (1) fire extinguisher located by room [redacted] in the SE hallway. The last documentation of the monthly inspection as being performed was on 04/04/25. 3. One (1) fire extinguisher located by room [redacted] in the Northeast (NE) hallway. The last documentation of the monthly inspection as being performed was on 04/04/25. 4. One (1) fire extinguisher located by room [redacted] in the Southwest (SW) hallway. The last documentation of the monthly inspection as being performed was on 04/04/25. B. On 10/23/25 at 2:41 PM, during an interview, the Administrator stated the fire marshall took the tags from the respective fire extinguishers and confirmed the fire extinguishers did not have proof that they were being inspected monthly.	8 063		

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