STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	4049	A. BUILDING: _____ B. WING _____	08/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BLUE HORIZON BOUTIQUE ASSISTED LIVING	2707 SPITZ STREET BUILDING B 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 a Full-Onsite survey completed on [redacted]23 for the state requirements of 7 NMAC 8.2, Regulations for Assisted Livings for Adults. Resident Census is 13 ABBREVIATIONS: Resident: R Direct Care Staff: DCS Individual Service Plan: ISP Individual Service Plans: ISPs	A 000		
A 026	7 NMAC 8.2.26 Individual Service Plan INDIVIDUAL SERVICE PLAN (ISP): An ISP shall be developed and implemented within ten (10) calendar days of admission for each resident residing in the facility. A. The ISP shall address those areas of need as identified in the resident evaluation and through staff observation. (1) The ISP shall detail the services that are provided by the facility as well as the services to be provided by other agencies. (2) The resident evaluation and the ISP shall be reviewed and if needed revised by a licensed practical nurse, registered nurse or a physician extender. (3) The ISP shall be reviewed and or revised at a minimum of every six (6) months or when there is a significant change in the resident ' s health status. B. The ISP shall include the following: (1) a description of identified needs as noted in the resident evaluation; (2) a written description of all services to be provided;	A 026	1. The correction to our ISP's to reflect goals and outcomes was corrected by working with the software engineers for our Resident Management System and a goals and outcomes section has been added. 2. To ensure ongoing compliance, we will meet with the RN's doing our assessments and train them on adding goals and outcomes. The administrator will also review all ISP's to ensure goals and outcomes are on the ISP. 3. Goals & Outcomes on all current residents will be updated and completed by [redacted]	

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A 026	Continued From page 1 (3) who will provide the services; (4) when or how often the services will be provided; (5) how the services will be provided; (6) where the services will be provided; (7) expected goals and outcomes of the services; (8) documentation of the facility ' s determination that it is able to meet the needs of the resident; (9) the level of assistance that the resident will require with activities of daily living and with medications; (10) a crisis prevention/intervention plan when indicated by diagnosis or behavior; and (11) current orders for all medications, including those authorized for PRN usage. [7.8.2.26 NMAC - Rp, 7.8.2.26 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.26 B (7) Based on record review and interview, the facility failed to ensure for [redacted] residents whose ISPs were reviewed for compliance, that they included goals and outcomes of the services provided. This deficient practice could likely result in residents not achieving the desired goals and outcomes of the services needed because the Direct Care Staff (DCS) do not know the goals of the care/services they are to provide. The findings are: A. Record review of R #1's ISP dated [redacted]/23, revealed that the ISP did not include goals and	A 026		

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A 026	Continued From page 2 outcomes. B. Record review of R #2's ISPs dated [redacted]/22, [redacted]/22, and [redacted]/23, revealed that the ISPs did not include goals and outcomes. C. Record review of R #3's ISPs dated [redacted]/21, [redacted]/22, [redacted]/22, and [redacted]/23, revealed that the ISPs did not include goals and outcomes. D. On [redacted]/23 at 8:34 am, during an interview with the Administrator, she confirmed that R #s 1-3 ISPs did not include goals and outcomes.	A 026		
A 036	7 NMAC 8.2.36 Nutrition NUTRITION: The facility shall provide planned and nutritionally balanced meals from the basic food groups in accordance with the " recommended daily dietary allowance " of the American dietetic association, the food and nutrition board of the national research council, or the national academy of sciences. Meals shall meet the nutritional needs of the residents in accordance with the " 2005 USDA dietary guidelines for Americans. " Vending machines shall not be considered a source of snacks. A. Dietary services policies and procedures. The facility will develop and implement written policies and procedures that are maintained on the premises and that govern the following requirements. (1) Meal service. The facility shall: (a) serve at least three (3) meals or their equivalent each day at regular times with no more than sixteen (16) hours between the evening meal and morning meal with snacks freely available; (b) provide snacks of nourishing quality and post	A 036	1. The drawers with crumbs in them, and all other drawers have, have had a deep cleaning done. 2. To ensure ongoing compliance, We will post a daily kitchen duty cleaning list to be signed off by kitchen staff. The administrator will also conduct weekly spot checks. 3. Cleaning was completed on [redacted], the kitchen duty cleaning list will be posted by [redacted]/23.	

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A 036	Continued From page 3	A 036		

on the daily menu;
(c) develop menus enjoyed by the residents and served at normal intervals appropriate to the residents ' preferences;
(d) post the weekly menu, including snacks where residents and families are able to view it; posted menus shall be followed and any substitution shall be of equivalent nutritional value and recorded on the posted menu; identical menus shall not be used within a one (1) week cycle;
(e) have special menus or meal items following guidelines from the resident ' s physician for residents who have medically prescribed special diets;
(f) serve all residents in a dining room except for residents with a temporary illness, or with documented specific personal preference to have meals in their room;
(g) allow sufficient time for meals to enable residents to eat at a leisurely pace and to socialize; and
(h) contact the resident ' s PCP within forty-eight (48) hours if a resident consistently refuses to eat.
(2) Staff in-service training. The facility shall provide an in-service training program for staff that are involved in food preparation at orientation and at least annually and that includes:
(a) instruction in proper food storage;
(b) preparation and serving food;
(c) safety in food handling;
(d) appropriate personal hygiene; and
(e) infectious and communicable disease control.
B. Dietary records. The facility shall maintain the following documentation onsite:
(1) a systematic record of all menus and revisions, including snacks, for a minimum of thirty (30) calendar days;

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A 036	Continued From page 4 (2) a systematic record of therapeutic diets as prescribed by a PCP; (3) a copy of the most recent licensing inspection and for facilities with 10 or more residents, a copy of the New Mexico environment department inspection with notations made by the facility of action taken to comply with recommendations or citations; and (4) a daily log of the recorded temperatures for all facility refrigerators, freezers and steam tables maintained and available for inspection for thirty (30) calendar days. C. Clean and sanitary conditions. All practices shall be in accordance with the standards of the state environment department, pursuant to 7.6.2 NMAC. (1) Kitchen sanitation. (a) Equipment and work areas shall be clean and in good repair. Surfaces with which food or beverages come into contact shall be of smooth, impervious material free of open seams, not readily corrodible and easily accessible for cleaning. (b) Utensils shall be stored in a clean, dry place protected from contamination. (c) The walls, ceiling and floors of all rooms that food or drink is stored, prepared or served shall be kept clean and in good repair. (2) Washing and sanitizing kitchenware. (a) All reusable tableware and kitchenware shall be cleaned in accordance with procedures that include separate steps for prewashing, washing, rinsing and sanitizing. (b) Proper dishwashing procedures and techniques shall be utilized and understood by the dishwashing staff. (c) Periodic monitoring of the operation of the detergent dispenser, washing, rinsing and sanitizing temperatures shall be performed and	A 036		

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A 036	Continued From page 5	A 036		

documented.
(d) When a dishwashing machine is utilized, the cleanliness of the machine, its jets and its thermostatic controls shall be monitored and documented by the facility. A monthly log of the recorded temperature of the dishwasher shall be maintained in the facility and available for inspection.
(3) Sinks for hand washing shall include hot and cold running water, hand-washing soap and disposable towels.
(4) All garbage and kitchen refuse that is not disposed of through a garbage disposal unit shall be kept in watertight containers with close-fitting covers and disposed of daily in a safe and sanitary manner.
(5) Cooks and food handlers shall wear clean outer garments and hair nets or caps and shall keep their hands clean at all times when engaged in handling food, drink, utensils or equipment in accordance with the local health authority. Disposable gloves shall be used in accordance with the local health authority.
D. Food management. The facility shall store, prepare, distribute and serve food under sanitary conditions and in accordance with the regulations governing food establishments of local health authority having jurisdiction, 7.6.2 NMAC.
(1) The facility shall ensure that a minimum of a three (3) calendar day supply of perishables and a five (5) calendar day supply of non-perishables or canned foods is available for the residents.
(2) The facility refrigerator and freezer shall have an accurate thermometer which reads within or not more than plus or minus three (3) degrees fahrenheit of the required temperature, located in the warmest section of the refrigerator and freezer and shall be accessible and easily read.
(a) The temperature of the refrigerator shall be

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A 036	Continued From page 6 thirty-five (35) - forty-one (41) degrees fahrenheit. (b) Freezer temperatures shall be maintained at zero (0) degrees fahrenheit or below. (3) Refrigerators and freezers shall be kept clean and sanitary at all times. Food stored in refrigerators and freezers shall be covered, dated and labeled. Unused leftover food shall be discarded after three (3) calendar days. (4) Steam tables, hot food tables, slow cookers, crock pots and other hot food holding devices shall not be used in heating or reheating food. Hot food temperatures shall be checked periodically to insure that a minimum of one hundred forty (140) degrees fahrenheit is maintained. (5) Medication, biological specimens, poisons, detergents and cleaning supplies shall not be kept in the same storage areas used for storage of foods. Medications shall not be stored in the refrigerator with food; an alternate refrigerator for medication shall be used pursuant to Subsection B of 7.6.2.8 NMAC. (6) Canned or preserved foods shall be procured from sources that process the food under regulated quality and sanitation controls. This does not preclude the use of local fresh produce. The facility shall not use home-canned foods. (7) Dry or staple food items shall be stored at least six (6) inches off the floor in a ventilated room that is not subject to sewage, waste water back-flow or contamination by condensation, leakage, rodents or vermin. (8) The facility shall ensure the following: (a) all perishable food is refrigerated and the temperature is maintained no higher than forty-one (41) degrees fahrenheit; (b) the temperature for all hot foods is maintained at one hundred forty (140) degrees fahrenheit; and	A 036		

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A 036	Continued From page 7 (c) all displayed or transported food is protected from environmental contamination and maintained at proper temperatures in clean containers, cabinets or serving carts. E. Milk. (1) Raw milk shall not be used. (2) Condensed, evaporated, or dried milk products that are nationally recognized may be employed as " additives " in cooked food preparation but shall not be substituted or served to residents in place of milk. F. Collateral requirements. Compliance with this rule does not relieve a facility from the responsibility of meeting more stringent municipal regulations, ordinances or other requirements of state or federal laws governing food service establishments. Local health authority having jurisdiction means municipal, county, state or federal agency(s) that have laws and regulations governing food establishments, liquid waste disposal, treatment facilities and private wells. [7.8.2.36 NMAC - Rp, 7.8.2.37 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.36 C (1) (b) Based on observation and interview, the facility failed to ensure kitchen utensils were stored in a clean, dry place protected from contamination. This deficient practice could likely cause the [redacted] residents listed on the census provided by the Administrative Assistant on [redacted]/23, to be at risk of contracting food borne illnesses if the utensils are not clean and sanitary (free of crumbs or dirt) and stored in a clean/dry	A 036		

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A 036	Continued From page 8 place. The findings are: A. On [redacted]/23 at 9:16 am, during an observation of the facility's kitchen, the following was found: 1. One dirty (crumbs and debris) utensil organizer/holder in a drawer near the back wall of the kitchen. 2. Two dirty utensil drawers under the sink on the kitchen island. B. On [redacted]/23 at 9:16 am, during an interview with DCS #5, she confirmed the utensil organizer and drawers near the back wall and under the sink of the kitchen island were dirty with crumbs and debris.	A 036		
A 042	7 NMAC 8.2.42 Maintenance of Building and Grounds MAINTENANCE OF BUILDING AND GROUNDS: The building(s) shall be maintained in good repair at all times. Such maintenance shall include, but is not limited to, the following areas: A. Storage areas/grounds. Storage areas and grounds shall be maintained in a safe, sanitary and presentable condition at all times. Storage areas and grounds shall be kept free from accumulation of refuse, weeds, discarded furniture, old newspapers or other items that create a fire hazard. B. Floors. Floors shall be maintained stable, firm and free of tripping hazards. [7.8.2.42 NMAC - Rp, 7.8.2.43 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by:	A 042	1. In order to correct this deficiency, the owner met with the building managers and maintenance staff and pointed out the findings. The maintenance staff cleaned all areas. 2. To ensure ongoing compliance, maintenance, administrator and building managers will do building perimeter walk-throughs Monday-Friday to ensure there is no debris. 3. Initial cleaning was done [redacted] and daily walkthroughs are are already being done effective [redacted]	

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A 042	Continued From page 9 7.8.2.42 A Based on observation and interview, the facility failed to ensure the facility storage areas and grounds were maintained in a safe, sanitary, and presentable condition. This deficient practice could likely result in the [redacted] residents identified on the resident census provided by the Administrative Assistant on [redacted]/23, to be at risk of harm if residents are exposed to unsanitary conditions, or trash containing bacteria, germs, or infectious material, and become ill. The findings are: A. On [redacted]23 at 9:25 am, during an observation of the outdoor/exterior grounds of the facility along the back/North side, the following was observed: 1. Pieces of shredded, brown paper. 2. Pieces of white paper towel/tissue. 3. A pink straw. 4. A white ping-pong ball. 5. An empty energy drink can. 6. An empty plastic bag. 7. A blue latex glove. 8. An empty fast-food wrapper. B. On [redacted]/23 at 9:26 am, during an observation of the outdoor/exterior grounds of the facility near the front entrance, a white piece of paper towel/tissue was found on the ground to the left of the door. C. On [redacted]/23 at 9:29 am, during an observation of the Northeast patio doorway entrance, a blue piece of trash (either latex or plastic) was found on the ground near the door. D. On [redacted]/23 at 10:50 am, during an interview	A 042		

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A 042	Continued From page 10 with DCS #2, he confirmed the above trash was found on the facility's outdoor/exterior grounds and stated he would inform management.	A 042		
A 047	7 NMAC 8.2.47 Lighting and Lighting Fixtures LIGHTING AND LIGHTING FIXTURES: A. All areas of the facility, including storerooms, stairways, hallways, and interior and exterior entrances shall be lighted to make the area clearly visible. B. Exits, exit-access ways and other areas used at night by residents and staff shall be illuminated by night lights or other continuous lighting. C. Lighting fixtures shall be selected and located to accommodate the needs and activities of the residents, with the comfort and convenience of the residents in mind. D. Lamps and lighting fixtures shall be shaded to prevent glare to the eyes of residents and staff, and protected from accidental breakage or shattering. E. Facilities with four (4) or more residents shall have emergency lighting to light exit passageways and the exterior area near the exits that activates automatically upon disruption of electrical service. F. Facilities with three (3) or fewer residents shall have a flashlight that is immediately available for use in lieu of electrically interconnected emergency lighting. [7.8.2.47 NMAC - Rp, 7.8.2.48 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.47 E	A 047	1. In order to correct this deficiency our fire maintenance and monitoring company was called out and set up an appointment for [redacted]/23 (their earliest available) 2. This will be monitored by maintenance checking and logging monthly. Administrator will review log. 3. Deficiency will be corrected on [redacted]/23	

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A 047	Continued From page 11 Based on observation and interview the facility failed to ensure that all the emergency lights in the facility were in working order. This deficient practice could likely result in the [redacted] residents identified on the resident census provided by the Administrative Assistant on [redacted]/23, to be at risk of harm, injury, or death, if there is a power outage or other emergency requiring evacuation and the residents cannot see to safely exit the building. The findings are: A. On [redacted]/23 at 8:50 am, during observation and testing of the emergency light across from the linen room failed to light up when tested. B. On [redacted]/23 at 8:52 am, during observation and testing of the emergency light on the right dining wall failed to light up when tested. C. On [redacted]/23 at 8:53 am, during observation and testing of the emergency light near room [redacted] failed to light up when tested. D. On [redacted]/23 at 8:55 am, during observation and testing of the emergency light at the hallway restrooms failed to light up when tested. E. On [redacted]/23 at 8:57 am, during observation and testing of the emergency light near resident room [redacted] and [redacted] failed to light up when tested F. On [redacted]23 at 8:58 am, during observation and testing of the emergency light on the left hand side of the living room (Northside) failed to light up when tested. G. On [redacted]/23 at 8:58 am, during observation	A 047		

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A 047	Continued From page 12 and testing of the emergency light at the Northwest corner close to resident rooms [redacted] failed to light up when tested. H. On [redacted]/23 at 8:59 am, during observation and testing of the emergency light on the West side near room #s [redacted]1 at the Southwest portion of the building failed to light up when tested. I. On [redacted]/23 at 9:01 am, during observation and testing of the emergency light near resident room #s [redacted] failed to light up when tested. J. On [redacted]/23 at 10:50 am, during an interview with the DCS [redacted] she confirmed that the emergency lights listed above failed to light up when tested.	A 047		
A 059	7 NMAC 8.2.59 Windows WINDOWS: A. Each sleeping room shall be provided with an exterior window. (1) The window shall be operable, screened and have a clear operable area of 5.7 square feet minimum; measured twenty (20) inches wide minimum and measured twenty-four (24) inches high minimum. (2) The top of the window sill shall not be more than forty-four (44) inches above the finished floor. B. Screens shall be provided on all operable windows. C. The proposed use of bars, grilles, grates or similar devices shall be reviewed and approved by the licensing authority prior to installation. D. Sleeping rooms, living rooms, activity room areas and dining room areas shall have a window	A 059	1. The correction was done by fixing the bent screens and the screen with the small hole. 2. To ensure ongoing compliance, administrator and building managers will look for items such as this during their daily walk-through. 3. This correction was made on [redacted]	

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	4049	A. BUILDING: _____ B. WING _____	08/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BLUE HORIZON BOUTIQUE ASSISTED LIVING	2707 SPITZ STREET BUILDING B LAS CRUCES, NM 88005

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A 059	Continued From page 13 area of at least one tenth (1/10) of the floor area with a minimum of ten (10) square feet. [7.8.2.59 NMAC - Rp, 7.8.2.52 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.59 B Based on observation and interview, the facility failed to ensure that all the facility's windows had screens that were in good repair. This deficient practice could likely result in the [redacted] residents identified on the census provided by the Administrative Assistant on [redacted]/23, to be at risk of injury or illness if they are exposed to bugs/insects, allergens, or debris coming in through the damaged and missing window screens. The findings are: A. On [redacted]23 at 9:20 am, during observation of the exterior of the facility, the following was observed: 1. The window screen on the window facing West, to the left of the front door, had a bent frame. 2. The window screen on the Northwest corner of the building had a bent frame. 3. The window on the Northeast corner of the building had a bent frame. B. On [redacted]/23 at 9:31 am, during an observation of the interior of the facility, the screen at the end of the hall near room [redacted] and [redacted] was observed to be damaged with a small hole in it. C. On [redacted]/23 at 1:59 pm, during an interview,	A 059		

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A 059	Continued From page 14 Owner #2 confirmed the window screen findings listed above.	A 059		
A 063	7 NMAC 8.2.63 Fire Extinguishers FIRE EXTINGUISHERS: Fire extinguisher(s) must be located in the facility, as approved by the state fire marshal or the fire prevention authority with jurisdiction. A. Facilities must as a minimum have two (2) 2A10BC fire extinguishers: (1) one (1) extinguisher located in the kitchen or food preparation area; (2) one (1) extinguisher centrally located in the facility; (3) all fire extinguishers shall be inspected yearly and recharged as needed; all fire extinguishers must be tagged noting the date of the inspection; (4) the maximum distance between fire extinguishers shall be fifty (50) feet. B. Fire extinguishers, alarm systems, automatic detection equipment and other fire fighting equipment shall be properly maintained and inspected as recommended by the manufacturer, state fire marshal, or the local fire authority. [7.8.2.63 NMAC - Rp, 7.8.2.62 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.63 B Reference 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	A 063	1. In order to correct this deficiency all fire extingishers were checked and initialed. Fire maintenance company will also put new tags on all extinguishers during their visit on [redacted] 2. This will be monitored by maintenance checking and logging monthly. Administrator will review log. 3. Deficiency will be corrected on [redacted]/23	

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A 063	Continued From page 15 30 day intervals. Fire extinguishers shall be inspected at more frequent intervals when circumstances require. Based on observation and interview, the facility failed to ensure that fire extinguishers were being inspected monthly as recommended by the manufacturer. This deficient practice could likely result in the [redacted] residents identified on the census provided by the Administrative Assistant on [redacted]/23, staff members, and other building occupants to be at risk of harm, injury, or death if a fire were to occur and the fire extinguishers did not work. The findings are: A. On [redacted]/23 at 8:36 am, during observation of the facility's fire extinguishers, it was found that 3 of 3 fire extinguishers had inspection tags that were not marked or initialed as being inspected for the months of April, May, June and July of 2023, after the last Annual Inspection completed in March of 2023. B. On [redacted]/23 at 10:50 am, during an interview with DCS #2, he confirmed the fire extinguishers in the facility had not been marked or initialed as being inspected for the months of April, May, June and July of 2023. C. On [redacted]/23 at 2:30 pm during an interview with the Administrator she confirmed that the extinguisher tags were not marked or initialed as being inspected for the months of April, May, June and July of 2023.	A 063		
A 068	7 NMAC 8.2.68 Hospice	A 068		

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A 068	Continued From page 16 HOSPICE: An assisted living facility that provides or coordinates hospice care and services shall meet the requirements in this section, in addition to the rules applicable to all assisted living facilities, 7.8.2 NMAC. A. Definitions: in addition to the requirements for all assisted living facilities pursuant to " DEFINITIONS, " 7.8.2.7 NMAC, the following definitions shall also apply. (1) " Hospice agency " means an organization, company, for-profit or non-profit corporation or any other entity which provides a coordinated program of palliative and supportive services for physical, psychological, social and the option of spiritual care of terminally ill people and their families. The services are provided by a medically directed interdisciplinary team in the person's home and the agency is required to be licensed pursuant to 7.12 NMAC. (2) " Hospice care " means a focus on palliative, rather than curative care. The goal of the plan of care is to help the patient live as comfortably as possible, with emphasis on eliminating or decreasing pain and other uncomfortable symptoms. (3) " Licensed assisted living provider " means a facility that provides twenty-four (24) hour assisted living and is licensed by the department of health. (4) " Hospice services " means a program of palliative and supportive services which provides physical, psychological, social and spiritual care for terminally ill patients and their family members. (5) " Care coordination requirements " means a written document that outlines the care and services to be provided by the hospice agency for assisted living residents that require hospice services.	A 068	1. In order to correct this deficiency the administrator will revise the current training plan and inrease the # of hospice related trainings. 2. This will be monitored by continuing to review monthly staff training hours. 3. Deficiency will be corrected by [redacted] 4. All staff hired on or before [redacted] will have the appropriate hours of hospice trainings completed by [redacted]	

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A 068	Continued From page 17 (6) " Palliative care " means a form of medical care or treatment that is intended to reduce the severity of disease symptoms, rather than to reverse progression of the disease itself or provide a cure. (7) " Terminally ill " means a diagnosis by a physician for a patient with a prognosis of six (6) months or less to live. (8) " Visit notes " means the documentation of the services provided for hospice residents and includes ongoing care coordination. B. Employee training and support. A facility that provides hospice services shall provide the following education and training for employees who assist with providing these services: (1) provide a minimum of six (6) hours per year of palliative/hospice care training, which includes one (1) hour specific to the hospice resident ' s ISP, in addition to the basic staff education requirements pursuant to 7.8.2.17 NMAC; and (2) offer an ongoing employee psychological support program for end of life care issues. C. Individual service plan (ISP) requirements. (1) Each resident who receives hospice services shall be provided the necessary palliative care to meet the individual resident ' s needs as outlined in the ISP and shall include one (1) hour of training specific to the resident for all direct care staff. (2) The assisted living facility, in coordination with the hospice provider, shall create an ISP that identifies how the resident's needs are met and includes the following: (a) the requirements set forth in the " Individual Service Plan, " 7.8.2.26 NMAC, and " Exceptions to admission, readmission and retention, " Subsection C of 7.8.2.20 NMAC; (b) what services are to be provided; (c) who will provide the services;	A 068		

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A 068	Continued From page 18 (d) how the services will be provided; (e) a delineation of the role(s) of the hospice provider and the assisted living facility in the ISP process; (f) documentation (visit notes) of the care and services that are provided with the signature of the person who provided the care and services; and (g) a list of the current medications or biologicals that the resident receives and who is authorized to administer them. (3) Medications shall be self-administered, self-administered with assistance by an individual that has completed a state approved program in medication assistance or administered by the following individuals: (a) a physician; (b) a physician extender (PA or NP); (c) a licensed nurse (RN or LPN); (d) the resident if their PCP has approved it; (e) family or family designee; and (f) any other individual in accordance with applicable state and local laws. D. Care coordination. (1) The assisted living facility shall be knowledgeable with regard to the hospice requirements pursuant to 7.12 NMAC and ensure that the hospice agency is well informed with regard to the assisted living provisions pursuant to Subsection C of 7.8.2.20 NMAC. (2) The assisted living facility shall hold a team meeting prior to accepting or retaining a hospice resident in accordance with " Exceptions to admission, readmission and retention, " Subsection C of 7.8.2.20 NMAC. (3) Upon admission of a resident into hospice care, the assisted living facility shall designate a section of the resident ' s record for hospice documentation.	A 068		

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A 068	Continued From page 19 (a) The facility shall provide individual records for each resident. (b) The hospice agency shall leave documentation at the facility in the designated section of the resident ' s record. (4) The assisted living facility shall provide the resident and family or surrogate decision maker with information on palliative care and shall support the resident ' s freedom of choice with regard to decisions. (5) Hospice services shall be available twenty-four (24) hours a day, seven (7) days a week for hospice residents, families and facility staff and may include continuous nursing care for hospice residents as needed. These services shall be delivered in accordance with the resident ' s individual service plan (ISP) and pursuant to 7.8.2 26 NMAC. (6) The assisted living facility shall ensure the coordination of services with the hospice agency. (a) The resident's individual service plan (ISP) shall be updated with significant changes in the resident ' s condition and care needs. (b) The assisted living facility shall receive information and communication from the hospice staff at each visit. (i) The information shall include the resident status and any changes in the ISP (i.e., medication changes, etc.). (ii) The information shall be in the form of a verbal report to the assisted living facility staff and also in the form of written documentation. (c) The assisted living facility or the family/resident shall reserve the right to schedule care conferences as the needs of the resident and family dictate. The care conferences shall include all care team members. (d) Concerns that arise with regard to the delivery of services from either the assisted living facility	A 068		

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A 068	Continued From page 20 or the hospice agency shall first be addressed with the facility administrator and the hospice agency administrator. (i) The process may be informal or formal depending on the nature of the issue. (ii) If an issue can not be resolved or if there is an immediate danger to the resident the appropriate authority shall be notified. E. Additional provisions. An assisted living facility that provides or coordinates hospice care and services shall make additional provisions for the following requirements: (1) individual services and care: each resident receiving hospice services shall be provided the necessary palliative procedures to meet individual needs as defined in the ISP; (2) private visiting space: (a) physical space for private family visits; (b) accommodations for family members to remain with the patient throughout the night; and (c) accommodations for family privacy after a resident ' s death. F. Medicare and medicaid restrictions. Assisted living facilities shall not accept a resident considered " hospice general inpatient " which would be billable to medicare or medicaid because the facility will not qualify for payment by medicare or medicaid. [7.8.2.68 NMAC - N, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.68 B (1) Based on record review and interview, the facility failed to ensure for Direct Care Staff (DCS) whose personnel files were reviewed for compliance had documentary evidence on file at the facility of receiving/completing the required	A 068		

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A 068	Continued From page 21 minimum of six (6) hours per year of palliative/hospice care employee training, which includes one (1) hour specific to the hospice resident's ISP. This deficient practice could likely negatively affect the health, safety, and welfare of the [redacted] residents identified as receiving hospice services on the resident census, provided by the Administrative Assistant on [redacted]/23, if the DCS who provide direct care to residents have not received the required trainings. The findings are: A. Record review of DCS #2's (hire date [redacted]/18) training records revealed he only received a total of 4.5 hours of hospice/palliative care training in 2022. B. Record review of DCS #3's (hire date [redacted]/21) training records revealed she only received a total of 5.25 hours of hospice/palliative care training in 2022. C. On [redacted]/23 at 8:34 am, during an interview with the Administrator, she confirmed DCS #s 2 & 3 did not have the required 6 hours of annual hospice/palliative care training.	A 068		
A 069	7 NMAC 8.2.69 Memory Care Units MEMORY CARE UNITS: An assisted living facility that provides a memory care unit to serve residents with dementia shall comply with the provisions of subsection A-J below in addition to the rules applicable to all assisted living facilities, 7.8.2 NMAC. A. Additional definitions: The following definitions,	A 069	1. In order to correct this deficiency the administrator will revise the current training plan and inrease the # of Alzheimer's related trainings. 2. This will be monitored by continuing to review monthly staff training hours. 3. Deficiency will be corrected by [redacted]/2023	

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A 069	Continued From page 22 in addition to those in 7.8.2.7 NMAC, shall apply. (1) " Alzheimer ' s " means a brain disorder that destroys brain cells, causing problems with memory, thinking and behavior that are severe enough to affect work, lifelong hobbies or social life. Alzheimer ' s gets progressively worse and is fatal. (2) " Care coordination agreement requirement " means a written document that outlines the care and services that are provided by other outside agencies for assisted living residents that require additional care and services. (3) " Dementia " means loss of memory and other mental abilities severe enough to interfere with daily life. It is caused by changes in the brain. (4) " Memory care unit " means an assisted living facility or part of or an assisted living facility that provides added security, enhanced programming and staffing appropriate for residents with a diagnosis of dementia, Alzheimer ' s disease or other related disorders causing memory impairments and for residents whose functional needs require a specialized program. (5) " Secured environment " means locked (secured/monitored) doors/fences that restrict access to the public way for residents who require a secure unit. B. Care coordination requirement. An assisted living facility that accepts residents with memory issues shall determine which additional services and care requirements are relevant to the resident and disease process. (1) The medical diagnosis and ISP shall be utilized in the determination of the need for additional services. (2) The assisted living facility shall ensure the coordination of services and shall have evidence of an agreement of care coordination for all	A 069	4. All staff hired on or before [redacted]/2023 will have the appropriate hours of Alzheimer's related trainings completed by [redacted]/2023.	

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A 069	Continued From page 23 services provided in the facility by an outside health care provider. C. Employee training. In addition to the training requirements for all assisted living facilities, pursuant to 7.8.2.17 NMAC, all employees assisting in providing care for memory unit residents shall have a minimum of twelve (12) hours of training per year related to dementia, Alzheimer ' s disease, or other pertinent information. D. Individual service plan (ISP). An assisted living facility that admits memory care unit residents shall create an ISP in coordination with the resident ' s primary care practitioner, in compliance with the requirements outlined in " Individual Service Plan, " 7.8.2.26 NMAC, pursuant to a team meeting as described in " Exceptions to admission, readmission and retention, " Subsection C of 7.8.2.20 NMAC, and which ensures the following criteria: (1) identification of the resident's needs specific to the memory care unit and the services that are provided; each memory unit resident shall receive the services necessary to meet the individual resident ' s needs; (2) medications shall be self-administered, self-administered with assistance by an individual that has completed a state approved program in medication assistance or administered by the following individuals: (a) a physician; (b) a physician extender (PA or NP); (c) a licensed nurse (RN or LPN); (d) the resident if their PCP has approved it; (e) family or family designee; and (f) any other individual in accordance with applicable state and local laws. E. Assessments and reevaluations. (1) An assessment shall be completed by a	A 069		

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A 069	Continued From page 24	A 069		

registered nurse or a physician extender within fifteen (15) days prior to admission. When emergency placement is warranted the fifteen (15) day assessment shall be waived and the assessment shall be completed within five (5) days after admission.
(a) The resident shall have a medical evaluation and documentation by a physician, physician's assistant or a nurse practitioner within six (6) months of admission.
(b) The pre-admission assessment shall include written findings, an evaluation of less restrictive alternatives and the basis for the admission to the secured environment. The written documentation shall include a diagnosis from the resident's PCP of Alzheimer's disease or other dementia and the need for the resident to reside in a memory care unit.
(c) Only those residents who require a secured environment placement or whose needs can be met by the facility, as determined by the assessment prior to admission or on review of the individual service plan (ISP), shall be admitted.
(2) A re-evaluation must be completed every six (6) months and when there is a significant change in the medical or physical condition of the resident that warrants intervention or different care needs, or when the resident becomes a danger to self or others, to determine whether the resident ' s stay in the assisted living facility memory care unit is still appropriate.
F. Documentation in the resident ' s record. In addition to the required documentation pursuant to 7.8.2.21 NMAC, the following information shall be documented in the resident ' s record:
(1) the physician ' s diagnosis for admission to a secure environment or a memory care unit;
(2) the pre-admission assessment; and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	4049	A. BUILDING: _____ B. WING _____	08/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BLUE HORIZON BOUTIQUE ASSISTED LIVING	2707 SPITZ STREET BUILDING B 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 069	Continued From page 25 (3) the re-evaluation(s). G. Secured environment. (1) Memory care unit residents may require a secure environment for their safety. A secured environment is any locked (secured/monitored) area in which doors and fences restrict access to the public way. These include but are not limited to: (a) double alarm systems; (b) gates connected to the fire alarm; and (c) tab alarms for residents at risk for elopement. (2) In addition to the interior common areas required by this rule, the facility shall provide a safe and secure outdoor area for the year round use by the residents. (a) Fencing or other enclosures shall prevent elopement and protect the safety and security of the residents. (b) Residents shall be able to independently access the outdoor areas. (3) Locked areas shall have an access code or key which facility employees shall have available on their person or on the locking unit itself at all times. H. Resident rights. In addition to the requirements pursuant to 7.8.2.32 NMAC, the following shall apply: (1) the resident's rights may be limited as required by their condition and as identified in the ISP; (2) the resident who believes that he or she has been inappropriately admitted to the secured environment may request the facility in contact the resident ' s legal guardian, or an advocate such as the ombudsman or the primary care practitioner; upon request, the facility shall assist the resident in making such contact. I. Disclosure to residents. A facility that operates a secured environment shall disclose to the	A 069		

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A 069	Continued From page 26 resident and the resident ' s legal representative, if applicable and prior to the resident ' s admission to the facility, that the facility operates a secured environment. (1) The disclosure shall include information about the types of resident diagnosis or behaviors that the facility provides services for and for which the staff are trained to provide care for. (2) The disclosure shall include information about the care, services and the type of secured environment that the facility and trained staff provide. J. Staffing. The facility shall provide the sufficient number of trained staff members to meet the additional needs of the residents in the secured environment. There must be at least one (1) trained staff member awake and in attendance in the secured environment at all times. [7.8.2.69 NMAC - N, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.69 C Based on record review and interview, the facility failed to ensure that the Direct Care Staff (DCS) completed a minimum of twelve (12) hours per year of training related to Dementia or Alzheimer's (memory loss) disease. This deficient practice could likely result in the [redacted] residents identified on the resident census list as having an Alzheimer's or Dementia diagnosis, provided by the Administrative Assistant on [redacted]/23, to be at risk of harm or injury if DCS have not received training on the proper methods of providing care and services for residents with Alzheimer's or Dementia.	A 069		

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A 069	Continued From page 27 The findings are: A. Record review of DCS #2's (hire date [redacted]/18) training records revealed he only received a total of 10.25 hours of Alzheimer's/Dementia training in 2022. B. Record review of DCS #3's (hire date [redacted]/21) training records revealed she only received a total of 9.25 hours of Alzheimer's/Dementia training in 2022. C. On [redacted]/23 at 8:34 am, during an interview with the Administrator, she confirmed DCS #s 2 and 3 did not have the required 12 hours of annual Alzheimer's/Dementia training documented. She stated she does some in-service training in addition to the online training, but did not document it.	A 069		