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	4107	A. BUILDING: _____ B. WING _____	C 07/27/2021

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MORNINGSTAR ASSISTED LIVING AND MEMORY CAI	2041 S PACHECO ST SANTA FE, NM 87505

(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 Complaint survey completed on 07/27 /21 for the state requirements of 7 NMAC 8.2, Regulations for Assisted Living Facilities. Complaint #NM 52182 was substantiated with deficiencies cited. [redacted]	A 000	**MORNINGSTAR OF SANTA FE** **Survey Exit: July 27, 2021** **Responses to the cited deficiencies do not constitute an admission or agreement by the community to the truth of the facts alleged or conclusion set forth in the statement of deficiencies. The plan of correction is prepared solely as a matter of compliance with federal and state law.**	
A 021	7 NMAC 8.2.21 Resident Records RESIDENT RECORDS: A. Record contents. A record for each resident shall be maintained in accordance with the specific requirements of this section. Entries in each resident's record shall be legible, dated and authenticated by the signature of the person making the entry. Resident records shall be readily available on site and organized utilizing a table of contents. Each resident record shall include: (1) the admission agreement records, as set forth in 7.8.2.20 NMAC; (2) the resident evaluation form, that is to be completed within fifteen (15) days prior to admission and updated at a minimum of every six (6) months; (3) the current ISP, that is to be completed within ten (10) calendar days of admission and updated at a minimum of every six (6) months; (4) the physical examination report; the physical examination report shall have been completed within the past six (6) months, by a primary care physician, a nurse practitioner or a physician ' s assistant and shall be on file in the resident ' s record within ten (10) days of admission;	A 021	**A 021** **RESIDENT RECORDS 7.8.2.21 B (3)** A) With respect to HOW the facility will CORRECT the problem identified in the deficiency list: Wellness Director (WD) or designee will ensure that a progress note is completed for each resident at a minimum of one per month, or more frequently if resident needs dictate. Each progress note will be completed, signed and stored in the community electronic health record. B) With respect to what the facility will do to PREVENT the same deficiency from recurring: The WD or designee will create and maintain a monthly calendar to maintain track of progress notes. This process will be implemented by October 15th 2021 and both the WD and Resident Care Coordinator (RCC) will be in-serviced on this system NLT September 30, 2021.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Margaret Bender — TITLE: Executive Director — (X6) DATE: 08/23/21

Revised per call with DOH 9/17/21
9/21/21

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A 021	Continued From page 1 (5) personal and demographic information for the resident, to include: (a) current names, addresses, relationship and phone numbers of family members, or surrogate decision makers updated as necessary; (b) resident's name; (c) age; (d) recent photograph; (e) marital status; (f) date of birth; (g) sex; (h) address prior to admission; (i) religion (optional); (j) personal physician; (k) dentist; (l) social history; (m) surrogate decision maker or other emergency contact person; (n) language spoken and understood; (o) legal documentation relevant to commitment or guardianship status; (p) current medications list; and (q) required diet; (6) unless included in the admission agreement, a separate written agreement between the facility and the resident relating to the resident's funds, in accordance with the facility's policy and procedures; (7) entries by direct care staff, appropriate health care professionals and others authorized to care for the resident; entries shall be dated and signed by the person making the entry and shall include significant information related to the ISP; (8) entries that provide a written account of all accidents, injuries, illnesses, medical and dental appointments, any problems or improvements observed in the resident, any condition that would indicate a need for alternative placement or medical attention and entries reflecting	A 021		

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A 021	Continued From page 2 appropriate follow-up; the maintenance of such written documentation in the resident record may be by copy of an incident or accident report, if the original incident or accident report is maintained elsewhere by the facility; (9) the medication assistance record (MAR); the MAR is the document that details the resident's medication; the MAR shall include all of the information pursuant to Subsection G of 7.8.2.35 NMAC of this rule; (10) progress notes completed by any contract agency (e.g., hospice, home health); the progress notes shall include the date, time and type of health services provided; (11) copies of all completed and signed transfer forms from the accepting facility when a resident is transferred to a hospital or another health care facility and when the resident is transferred back to the facility; and (12) upon the death or transfer of a resident, documentation of the disposition of the resident's personal effects and money or valuables that are deposited with the assisted living facility. B. Resident records maintenance. (1) Current resident records shall be maintained on-site and stored in an organized, accessible and permanent manner. (2) The facility shall establish a policy to maintain and ensure the confidentiality of resident records, including the authorized release of information from the resident records. (3) Non-current resident records shall be maintained by the facility against loss, destruction and unauthorized use for a period of not less than five (5) years from the date of discharge and readily available within twenty-four (24) hours of request. (4) There shall be a policy and procedure in place for record retention in the event of facility closure.	A 021		

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A 021	Continued From page 3 (5) Failure to follow facility policies is grounds for sanctions. [7.8.2.21 NMAC - Rp, 7.8.2.22 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.21 B (3) Based on record review and interview, the facility failed to ensure for 1 (R #4) of 1 (R #4) former resident whose records were reviewed for compliance, were maintained onsite and available within twenty-four (24) hours of request. This deficient practice could likely result in harm to the residents health and safety if their records are not available for review by the Licensing Authority and there is no oversight of the care and services received while residing at the facility. The findings are: A. Record request for progress notes for R #4 for the months of October 2019, November 2019, December 2019, January 2020, March 2020, and April 2020, revealed the records were not onsite and/or available for review. B. On 07/27/21 at 7:53 am, during an interview with the Administrator, she confirmed that not all of R #4's records were onsite or available for review within twenty-four (24) hours of the request.	A 021		
A 025	7 NMAC 8.2.25 Resident Evaluation	A 025		

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A 025	Continued From page 4 RESIDENT EVALUATION: A. A resident evaluation shall be completed by an appropriate staff member within fifteen (15) days prior to admission to determine the level of assistance that is needed and if the level of services required by the resident can be met by the facility. B. The initial resident evaluation shall establish a baseline in the resident ' s functional status and thereafter assist with identifying resident changes. The resident evaluation shall be reviewed and updated at a minimum of every six (6) months or when there is a significant change in the resident ' s health status. C. The resident ' s evaluation shall be documented on a resident evaluation form and at a minimum include the following abilities, behaviors or status: (1) activities of daily living; (2) cognitive abilities; reasoning and perception; the ability to articulate thoughts, memory function or impairment, etc; (3) communication and hearing; ability to communicate needs and understand instructions, etc; (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	A 025	A 025 **RESIDENT EVALUATION 7.8.2.25 C (12)** A) With respect to HOW the facility will CORRECT the problem identified in the deficiency list: The master resident evaluation template in the EHR has been updated to reflect resident's nutritional status and risk factors. B) With respect to what the facility will do to PREVENT the same deficiency from recurring: 9/30/21 ASC ok per Admin 1. WD or designee will complete evaluations on residents as scheduled in accordance with NM regulation and MorningStar policy, which will include the nutritional portion and risk factors. 2. RCC or designee will ensure every resident has a weight completed at least monthly (more frequently as ordered by their provider, entered in the EHR and alerts will be generated for any significant change (+/- 5% or more).	

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A 025	Continued From page 5 medical needs such as hospice; and (17) safety needs/high risk behaviors; history of falls agitation, wandering, fire safety issues, etc. D. The resident evaluation shall include a history and physical examination and an evaluation report by a physician or a physician extender within six (6) months of admission. A resident shall have a medical evaluation by a physician or a physician extender at least annually. E. The resident evaluation shall be reviewed and if needed revised by a licensed practical nurse, registered nurse or physician extender at the time the individual service plan is reviewed, at a minimum of every six (6) months or when a significant change in health status occurs. [7.8.2.25 NMAC - Rp, 7.8.2.25 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.25 C (12) Based on record review and interview, the facility failed to ensure for 1 (R #4) of 6 (R #s 1 through 6) residents whose resident evaluations were reviewed for compliance contained information regarding the resident's nutritional status. This deficient practice could likely result in harm if staff do not know the residents nutritional status and the resident is at risk for malnutrition. The findings are: A. Record review of R #4's resident evaluation dated 03/06/20 revealed, that the resident was reported to have no issues that may affect their nutritional status.	A 025		

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A 025	Continued From page 6 B. Record review of R #4's resident evaluations from October 2019 through March 2020 revealed the following: 1 [redacted]had lost a total of [redacted] 2. R #4's initial evaluation 10/21/19 stated [redacted] weighed [redacted] 3. Evaluations dated 12/30/19 and 01/29/20 did not include R #4's weight. 4. Evaluation dated 03/06/20 revealed [redacted] weighed [redacted] 5. None of the evaluations from October 2019 through March 2020 addressed the weight loss for R #4. C. On 07/27/21 at 7:53 am, during an interview with the Administrator, she confirmed that R #4's resident evaluation dated 03/06/20 did not note any issues that may affect nutritional status and that weight was not addressed on any of the evaluations.	A 025		
A 026	7 NMAC 8.2.26 Individual Service Plan INDIVIDUAL SERVICE PLAN (ISP): An ISP shall be developed and implemented within ten (10) calendar days of admission for each resident residing in the facility. A. The ISP shall address those areas of need as identified in the resident evaluation and through staff observation. (1) The ISP shall detail the services that are provided by the facility as well as the services to be provided by other agencies. (2) The resident evaluation and the ISP shall be reviewed and if needed revised by a licensed practical nurse, registered nurse or a physician extender. (3) The ISP shall be reviewed and or revised at a minimum of every six (6) months or when there is	A 026		

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A 026	Continued From page 7 a significant change in the resident ' s health status. B. The ISP shall include the following: (1) a description of identified needs as noted in the resident evaluation; (2) a written description of all services to be provided; (3) who will provide the services; (4) when or how often the services will be provided; (5) how the services will be provided; (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 5 (R #s 1, 3 through 6) of 6 (R #s 1 through 6) residents whose Individual Service Plans (ISPs) were reviewed for compliance included: 1. Goals for each service listed on the ISP. 2. Outcomes listed for the goals on the ISP. 3. A signature by the facility staff/nurse, or resident/legal representatives to show they	A 026	**A 026** **INDIVIDUAL SERVICE PLAN 7.8.2.26 B (7)** A) With respect to HOW the facility will CORRECT the problem identified in the deficiency list: 1. WD and RCC will conduct a 100% audit of all current residents' service plans and ensure that all applicable parties have signed the SP. This audit will be completed on or before September 30th, 2021 and will be documented on a resident roster audit tool. B) With respect to what the facility will do to PREVENT the same deficiency from recurring: 1. Service plans are to be updated as scheduled in accordance with NM regulation and MorningStar policy. Each time a service plan is updated, RCC will ensure a copy is provided to the resident or Power of Attorney (POA) and RCC will request (and document attempt) to obtain a signed copy. 2. WD or designee will ensure that the Service Plan includes a focus, goal, intervention, and outcome.	

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A 026	Continued From page 8 participated in the development of R #4's ISP. This deficient practice could likely result: 1. In the residents not reaching or maintaining their goals/outcomes because the Direct Care Staff (DCS) are not aware of what/how to provide the necessary care and services needed. 2. Residents/legal representatives were not included in the development of the ISP and are not aware of the care and services the facility will provide. The findings are: A. Record review of R #1's ISP dated 03/02/20 revealed, there were no goals or outcomes listed on the ISP. B. Record review of R # 3's ISP dated 03/02/20 revealed, there were no outcomes for the goals listed on the ISP. C. Record review of R # 4's ISP dated 03/02/20 revealed the following: a. There were no goals listed in the areas of Bathing enabled devices, grooming level of assistance, and Healthcare appointments. B. There were not outcomes listed for any of the goals listed on the ISP. C. The ISP was not signed by the resident/legal representative or staff who developed and implemented it. D. Record review of R #5's ISP dated 03/02/20 revealed, there no outcomes for the goals listed on the ISP. E. Record review of R #6's ISP dated 03/02/20 revealed there were no outcomes listed for the	A 026		

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A 026	Continued From page 9 goals listed on the ISP. F. On 07/15/21 at 2:00 pm, during an interview with R #4's Power of Attorney (POA), she confirmed that she had not participated in the development of the ISP or received copies when requested. G. On 07/16/21 at 2:30 pm, during an interview with the Administrator, she confirmed that the: 1. ISPs for R #'s 1, 3 - 6 did not include any outcomes for the specific goals. 2. ISP for R #4 had not been signed by the resident/legal representative, nurse, or facility staff. 3. The Administrator stated that she was not aware that the family had requested a a copy of the ISP and were denied those records, because she was not working at the facility at that time. H. On 08/04/21 at 1:58 pm, during an interview with the Administrator, she confirmed that R #4's ISP dated 03/02/20 did not contain goals in the areas of Bathing enabled devices, Grooming level of assistance, and Healthcare appointments.	A 026		
A 032	7 NMAC 8.2.32 Reporting of Incidents REPORTING OF INCIDENTS: A. The facility shall insure that all suspected cases or known incidents of resident abuse, neglect or exploitation are reported in accordance with 7.1.13 NMAC. (1) The facility shall also report any incident or unusual occurrence which has or could threaten the health, safety, or welfare of the residents and staff to the licensing authority complaint hotline within twenty-four (24) hours or by the next business day, if it is a weekend or a holiday.	A 032		

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A 032	Continued From page 10 (2) The facility shall not delay a report to the complaint hotline while an internal investigation is conducted. B. The facility is responsible for conducting and documenting the investigation of all incidents within five (5) business days and shall submit a copy of the investigation report to the licensing authority. A copy of the report and the documentation, including the date and time that it was submitted to the licensing authority, shall be maintained on file at the facility. The investigation shall include the following: (1) a narrative description of the incident; (2) the result of the facility's investigation shall be recorded on the state approved incident report form for the current year, pursuant to 7.1.13 NMAC; and (3) plans for further actions in response to the incident. [7.8.2.32 NMAC - Rp, 7.8.2.32 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: Surveyor: Karaara, Millie 7.8.2.32 A (1 & 2) B (1 & 2) 7.1.13 INCIDENT REPORTING, INTAKE, PROCESSING AND TRAINING REQUIREMENTS Refer to 7.1.13.7 W. & 8 B. (2) W. " Reportable incident " means possible abuse, neglect, exploitation, injuries of unknown origin and other events including but not limited to falls which cause injury, unexpected death, elopement, medication error which causes or is	A 032	**A 032** **INCIDENT REPORTING, INTAKE, PROCESSING AND TRAINING REQUIREMENTS 7.8.2.32 A (1 & 2) B (1 & 2)** A) With respect to HOW the facility will CORRECT the problem identified in the deficiency list: 1. Executive Director (ED) or designee will review all incident reports dating back 60 days and ensure all reportable incidents have been reported to the NMDOH in within 24 hours or next business day. This audit will be completed on or before September 30th, 2021. B) With respect to what the facility will do to PREVENT the same deficiency from recurring: 1. ED, WD and RCC will all be in-serviced on reporting requirements and procedures in accordance with NMDOH regulations. In-service will take place on or before September 30th, 2021 and documented on an in-service sign-in sheet.	

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A 032	Continued From page 11 likely to cause harm, failure to follow a doctor's order or an ISP or any other incident which may evidence abuse, neglect, or exploitation. B. (2) Division incident report form and notification by licensed health care facilities: The licensed health care facility shall report incidents utilizing the division's incident report form consistent with the requirements of the division's incident management system guide and CMS regulations as applicable. The licensed health care facility shall ensure that all incident report forms alleging abuse, neglect, exploitation, injuries of unknown origin or other reportable incidents are submitted by a reporter with direct knowledge of an incident, are completed on the bureau's incident report form and received by the division within twenty-four (24) hours of an incident or allegation of an incident or the next business day if the incident occurs on a weekend or a holiday. The licensed health care facility shall ensure that the reporter with the most direct knowledge of the incident assists with the preparation of the incident report form Based on record review and interview the facility failed to ensure for 5 (R #s 2 through 6) of 6 (R #s 1 through 6) whose internal incident reports were reviewed for compliance had been reported to the Licensing Authority within 24-hours, or the next business day, if a holiday or a weekend. This deficient practice could likely result in the residents being at risk of harm, injury, or death if, there is no oversite by the Licensing Authority. The findings are: A. Record review of R #2's internal incident report dated 06/04/21, revealed that: 1. At 11:40 am, R #2 called and reported [redacted]	A 032		

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A 032	Continued From page 12 was hot all over and was not making any sense when [redacted] spoke. 2. Direct Care Staff (DCS #8) took the resident's blood sugar level and it was 40. 3. DCS #8 called the on-call nurse and Resident Care Coordinator who called 911. 4. R #2 was taken to the hospital. 5. There was no documentation that the incident was reported to the Licensing Authority within 24 hours or the next business day if a weekend or holiday. B. Record review of R #3's internal incident reports revealed that the facility failed to report the following incidents to the Licensing Authority within 24 hours or the next business days if a weekend or a holiday: 1. On 09/30/20 at 08:30 am, DCS #2 and another caregiver went to change R #3 (bed-bound), to give breakfast, and medication; they noticed a pressure sore of R #3's left foot, and right foot was also starting to get red. DCS #1 (Care coordinator) was alerted. There were no other information was given regarding further treatment. 2. On 01/27/21 at 4:23 pm, DCS #6 was getting R #3 from the bathroom when R #3 let go of the bars and fell into the the shower on [redacted] eft side and was screaming in pain. Emergency Medical Technicians (EMT's) took R #3 to the hospital. 3. There was no documentation that the incidents were reported to the Licensing Authority within 24 hours or the next business day if a weekend or holiday. C. Record review of R #4's internal incident lists and reports revealed the facility failed to report the following incidents to the Licensing Authority within 24 hours or the next business day if a	A 032		

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A 032	Continued From page 13 weekend or holiday: 1. On 11/01/19, R #4 had an unwitnessed fall that was documented on the incident list, but there was no documentation if there were any injuries, an internal incident report was completed, or that the incident was reported to the Licensing Authority. 2. On 01/31/20, R #4 had an altercation documented on the incident list, but there was no documentation that an internal incident report was completed, if any there were any injuries or who R #4 had altercation with, or that it was reported to the Licensing Authority. 3. On 03/04/20 at 07:30 pm, internal incident report revealed R #4 was walking unsteady and fell hitting his head on the floor. 911 was called and family was notified. No hospitalization. 4. On 02/08/21 R #4 had an incident described as "other" on the incident list. No explanation as to what happened or what occurred during the altercation, if there were injuries, or if the incident was reported to the Licensing Authority. D. Record review of R #5's internal incident reports revealed that the facility failed to report the following incidents to the Licensing Authority: 1. On 01/03/21 at 05:35 pm, R #5 was found on the floor (unwitnessed fall) by a DCS # 9. R #5 informed the Care manager (DCS #10); that [redacted] right shoulder hurt. R #5 was sent by the Wellness Director to the hospital for an evaluation. 2. On 04/25/21 at 02:10 pm, R #5 was found on the floor - unwitnessed fall. 3. On 05/30/21 at 09:00 pm, R #5 was found on the floor and stated [redacted] had fallen and hi[redacted] head on the floor. On the written report. DCS #3 states medication (not specified) was given.	A 032		

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A 032	Continued From page 14 E. Record review of R #6's internal incident reports revealed the facility failed to report the following incidents to the Licensing Authority: 1. On 06/09/20 at 7:13 am, R #6 was found on the floor holding a tissue full of blood by DCS #2. [redacted] had skin tear on upper top of the nose and 2 skin tears underneath the right eye. 911 was called and when EMTs arrived R #6 refused care. EMTs advised DCS #2 to put pressure on skin tears to stop bleeding and put antibiotic cream and Band-Aid. DCS #2 informed Care Coordinator and nurses of the situation and family was called. 2. On 09/03/20 at 07:15 pm, R #6 was walking in from patio and fell onto his back. R #6 was unable to explain hov[redacted] fell (unwitnessed fall). 3. On 10/06/20 at 12:19 pm, R #6 was found on the floor i[redacted] room with two bumps or[redacted] forehead. The right side was bleeding/rug burn and the left side was bruised with a bump. DCS called the Care Coordinator who called 911. R #6 was taken to Emergency Room (ER) for evaluation. 4. On 10/28/20 at 11:30 am, R #6 was walking down the hallway wher[redacted] fell hitting the left side of [redacted] face that gave [redacted] a laceration above [redacted] eyebrow, a skin tear to the left backside of [redacted] hand, and some scrapes to [redacted] right hand. [redacted] was also complaining of left knee pain which was bruised. R #6 was [redacted] and did not know what happened but kept asking if [redacted] had fallen. 911 was called and the Power of Attorney (POA) for R #6 was informed immediately. Gauze applied to [redacted] head and hand to stop bleeding. 5. On 04/08/21 at 10:11 am, R #6 was found on the floor i[redacted] room by DCS #6. [redacted] had 2 scraps on [redacted] left knee. [redacted] feet were tangled in the blanket. DCS #6 called the a second direct	A 032		

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A 032	Continued From page 15 care staff for back up/help. 6. On 04/18/21 at 1:50 pm, R #6 was found on [redacted] back in the courtyard with [redacted] hands behind [redacted] head by Care Manager. R #6 said [redacted] had slipped and fallen (unwitnessed fall). F. On 07/15/21 at 2:00 pm, during an interview with the Administrator, she confirmed that the above listed incidents for R #s 2-6 had not been reported to the Licensing Authority.	A 032		
A 033	7 NMAC 8.2.33 Resident Rights 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	A 033	**A 033** **7 NMAC 8.2.33 RESIDENT RIGHTS** A) With respect to HOW the facility will CORRECT the problem identified in the deficiency list: 1. RCC designee will ensure there is a current and accurate weight on all residents on or before September 30th, 2021. Any identified significant changes in weight will be communicated with the POA and PCP within 48 hours. Communication with POA and PCP will be documented in appropriate progress notes in the EHR. 2. Any residents identified to have a significant change in weight will have their evaluation and/or service plan updated to reflect appropriate interventions. This will be completed on or before October 15th, 2021. B) With respect to what the facility will do to PREVENT the same deficiency from recurring: 1. WD or designee will ensure weights are completed monthly and will review any changes in weight (loss or gain) monthly to ensure appropriate interventions and communication with all appropriate parties. This will be tracked using the reporting functions within the EHR.	

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A 033	Continued From page 16 include the telephone numbers for the incident management hotline and for the state ombudsman program. D. To protect resident rights, the facility shall: (1) treat all residents with courtesy, respect, dignity and compassion; (2) not discriminate in admission or services based on gender, sexual orientation, resident's age, race, religion, physical or mental disability, or nationality; (3) provide residents written information about all services provided by the facility and their costs and give advance written notice of any changes; (4) provide residents with a safe and sanitary living environment; (5) provide humane care for all residents; (6) provide the right to privacy, including privacy during medical examinations, consultations and treatment; (7) protect the confidentiality of the resident ' s medical record; (8) protect the right to personal privacy, including privacy in personal hygiene; privacy during visits with a spouse, family member or other visitor; and privacy in the resident's own room; (9) protect the right to communicate privately and freely with any person, including private telephone conversations and private correspondence; and the right to receive visits from family, friends, lawyers, ombudsmen and community organizations; (10) prohibit the use of any and all physical and chemical restraints; (11) ensure that residents: (a) are free from physical and emotional abuse neglect and misappropriation/or exploitation; (b) are free from financial abuse and misappropriation by facility staff or management; (c) are free to participate in religious, social,	A 033		

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A 033	Continued From page 17 community and other activities and freely associate with persons in and out of the facility; (d) are free to leave the facility and return without unreasonable restriction; (e) are given a fifteen (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 fourteen (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	A 033		

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A 033	Continued From page 18 or discharge. E. The resident's rights shall not be restricted unless this restriction is for the health and safety of the resident, agreed to by the resident or the resident ' s surrogate decision maker and outlined in the resident ' s individual service plan. [7.8.2.33 NMAC - Rp, 7.8.2.34 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.33 D (j) 7.8.2.7 DEFINITIONS: . . . AW. "Neglect" means the failure to provide goods and services necessary to avoid physical harm, mental anguish or mental illness and is defined in the Incident Reporting Intake, Processing & Training Requirements, 7.1.13 NMAC. 7.1.13.7. DEFINITIONS: . . . T. "Neglect" means the failure of the caretaker/staff to provide basic needs of a person, such as clothing, food, shelter, supervision and care for the physical and mental health of that person. Neglect causes, or is likely to cause, harm, or death to a person. Based on record review and interview, the facility failed to ensure for 1 (R #4) of 6 (R #s 1 through 6) residents whose resident charts were reviewed for compliance, that the resident was not being neglected by not: 1. Intervening when R #4 had a significant weight loss.	A 033		

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A 033	Continued From page 19 2. Notifying the Primary Care Provider (PCP) within 48 hours of the resident consistently refusing to eat. 3. Involving the resident and/or Power of Attorney (POA) to participate in the development of the Evaluations/ISPs. This deficient practice likely resulted in harm to the resident due to the significant weight loss. The findings are: A. Record review of R #4's resident evaluations from October 2019 through March 2020 revealed the following: 1. [redacted] had lost a total of 57 pounds (lbs). 2. R #4's initial evaluation 10/21/19 stated [redacted] weighed 192 lbs. 3. Evaluations dated 12/30/19 and 01/29/20 did not include R #4's weight. 4. Evaluation dated 03/06/20 revealed [redacted] weighed 135 lbs. 5. None of the evaluations from October 2019 through March 2020 addressed R #4's continual weight loss and refusals to eat. B. Record review of R #4's resident evaluations and ISPs dated December 2019, February 2020, and March 2020, revealed: 1. Neither the resident or POA had signed that they had participated in the development and implementation of R #4's ISPs. 2. There was no documentation that the resident or POA had been invited to participate in the development of R #4's Evaluations and ISPs and received a copy when requested. C. Record review of R #4's ISP initiate on 02/24/20 revealed it stated that weights would be monitored monthly and any concerns would be reported to the resident's PCP.	A 033		

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A 033	Continued From page 20 D. Record review of R #4's resident chart revealed no documentation that resident's PCP was notified of [redacted] significant weight loss of 57 lbs, refusals to eat, and not eating more that 50 % of his meals. E. On 07/15/21 at 2:00 pm, during an interview with R #4's POA, she confirmed that she had not participated in the development of the Evaluations/ISPs or received copies when requested. The POA stated the resident lost over [redacted] lbs. from October 2019 to March 2020, and nothing was done to address his weight loss. F. On 07/16/21 at 9:44 am, during an interview with the Resident Care Coordinator, she confirmed that R #4's lost weight from October 2019 through March 2020 and that she did not think she notified R # 4's PCP, POA or anyone else regarding the weight loss. She confirmed that R #4 had a physician's order and prescription for a health supplement beverage for weight loss and had been drinking it as prescribed. G. On 07/27/21 at 7:53 am, during an interview with the Administrator, she confirmed that: 1. R #4 had lost [redacted] lbs. from October 2019 through March 2020. 2. She did not know if R #4's PCP had been contacted regarding [redacted] weight loss because she was not working in the facility at that time. 3. The weight loss for R #4 had not been addressed in the 12/30/19 and 01/29/20 resident evaluations or ISPs 4. R #4's Evaluations and ISPs had not been signed by the resident, POA, or facility staff. 5. She did not know if the POA had been invited to participated in the development of the	A 033		

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A 033	Continued From page 21 evaluations/ISPs or received copies when requested, because she was not working at the facility at that time.	A 033		
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 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	A 036	**A 036** **7 NMAC 8.2.36 NUTRITION** A) With respect to HOW the facility will CORRECT the problem identified in the deficiency list: 1. RCC designee will ensure there is a current and accurate weight on all residents on or before September 30th, 2021. Any identified significant changes in weight will be communicated with the POA and PCP within 48 hours. Communication with POA and PCP will be documented in appropriate progress notes in the EHR. Consistent refusal to eat will also be reported to POA and PCP> 2. Any residents identified to have a significant change in weight will have their evaluation and/or service plan updated to reflect appropriate interventions. This will be completed on or before October 15th, 2021. B) With respect to what the facility will do to PREVENT the same deficiency from recurring: 1. WD or designee will ensure weights are completed monthly and will review any changes in weight (loss or gain) monthly to ensure appropriate interventions and communication with all appropriate parties. This will be tracked using the reporting functions within the EHR.	

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A 036	Continued From page 22 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; (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	A 036		

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A 036	Continued From page 23 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 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	A 036		

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A 036	Continued From page 24 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 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	A 036		

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A 036	Continued From page 25 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 (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	A 036		

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A 036	Continued From page 26 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 A (1) (h) Based on record review and interview, the facility failed to ensure for 1 (R #4) of 6 (R #s 1 through 6) residents whose records were reviewed for compliance, that the resident's Primary Care Physician (PCP) was contacted within forty-eight (48) hours of the resident consistently refusing to eat, and that R #4's weight loss was being addressed in the resident Evaluations and Individual Service Plans (ISPs). These deficient practices likely resulted in R #4 having significant weight loss. The findings are: A. Record review of R #4's progress notes for the month of February 2020 revealed there were fourteen (14) times R #4 refused food or ate less than 50% of his meal. There was no documentation that the PCP was contacted or	A 036		

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A 036	Continued From page 27 that the facility was concerned or had addressed the weight loss or poor nutrition. B. On 07/15/21 at 2:00 pm, during an interview with R #4's Power of Attorney (POA), she confirmed that in April 2020 after the resident was discharged, it was discovered that he lost over [redacted] lbs. while at the facility from October 2019 through March 2020, and that this was not addressed by the facility. C. Record review of R #4's resident evaluations and Individual Service Plans (ISPs) from October 2019 through March 2020 revealed the following: 1. R #4's initial evaluation 10/21/19 identified [redacted] weighed [redacted] lbs. 2. Evaluations dated 12/30/19 and 01/29/20 did not include R #4's weight. 3. Evaluation dated 03/06/20 revealed [redacted] weighed [redacted] lbs. 4. [redacted] had lost a total of [redacted] lbs. 5. No changes were made to the dietary portions of the ISP dated 03/06/2020. 6. None of the evaluations from October 2019 through March 2020 addressed the weight loss for R #4. D. On 07/27/21 at 7:53 am, during an interview with the Administrator, she confirmed that: 1. R #4's progress notes provided documentation of multiple instances of R #4 refusing food or only eating less than 50% of [redacted] meal. 2. There was no documentation available that R #4's PCP being contacted regarding this issue. 3. The Administrator also confirmed that R #4's refusals to eat or weight loss were not being addressed in the evaluations and ISPs.	A 036		

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A 068	Continued From page 28 7 NMAC 8.2.68 Hospice 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	A 068	A 068 **HOSPICE 7.8.2.68 B (1)** A) With respect to HOW the facility will CORRECT the problem identified in the deficiency list: 1. All direct care staff will receive initial training on hospice/palliative/end of life care on or before September 30, 2021. Training records will be uploaded and maintained in the LMS. 2. Regular training will be held through-out the year to ensure annual compliance. Training records will be uploaded and maintained in the LMS. B) With respect to what the facility will do to PREVENT the same deficiency from recurring: 1. Business Office Manager (BOM) or designee will ensure that all required team members receive Three (3) hours of End of Life training will be provided through the LMS twice a year for a total of 6 hours annually. All training records will be uploaded and maintained in the LMS training database.	

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A 068	Continued From page 29 assisted living residents that require hospice services. (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;	A 068		

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A 068	Continued From page 30 (b) what services are to be provided; (c) who will provide the services; (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	A 068		

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A 068	Continued From page 31 section of the resident ' s record for hospice documentation. (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.	A 068		

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A 068	Continued From page 32 (d) Concerns that arise with regard to the delivery of services from either the assisted living facility 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 that the Direct Care Staff (DCS) had completed a minimum of six (6) hours per	A 068		

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A 068	Continued From page 33 year of palliative/hospice care training. This deficient practice could likely result in the 6 (R #s 1 through 6) residents identified as receiving hospice care on the resident census list provided by the Administrator on 07/14/21, to be at risk of harm or injury if DCS have not received training on the proper methods of providing care and services. The findings are: A. Record review of staff training files for DCS #s 1 through 5 revealed the following DCS did not received the 6 hours of annual palliative/hospice care training: 1. DCS #1 only had 1 (one) hour of palliative/hospice care training. 2. DCS #2 had zero (0) hours of palliative/hospice care training. 3. DCS #4 had zero (0) hours of palliative/hospice care training. 4. DCS #5 had zero (0) hours of palliative/hospice care training. B. Record review of a letter provided by the Administrator from the hospice agency stated that hospice/palliative care training was completed, but it did not say how many hours of training was provided or which DCS attended the training C. On 07/16/21 at 2:30 pm, during an interview with the Administrator and the Resident Care Coordinator, they confirmed that DCS #s 1, 2, 4, and 5 had not received the required (6) hours of palliative/hospice care training per year.	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	A 069		

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A 069	Continued From page 34 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, 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	A 069	**A 069** **MEMORY CARE UNITS 7.8.2.69 C** A) With respect to HOW the facility will CORRECT the problem identified in the deficiency list: 1. All direct care staff will receive their initial dementia training of no less than 2 hours per on or before September 30th. All training records will be uploaded and maintained in the LMSs training database. 2. . Regular training will be held throughout the year to ensure annual compliance. Training records will be uploaded and maintained in the LMS. B) With respect to what the facility will do to PREVENT the same deficiency from recurring: 1. Business Office Manager (BOM) or designee will ensure that all required team members receive Three (3) hours of End of Life training will be provided through The LMS each quarter for a total of 12 hours annually. This will be accomplished through a combination of The LMS, Lavender Sky and/or other Certified Dementia curriculum. All training records will be uploaded and maintained in the LMS training database. **ED will meet with community leadership to review audit tools, incident reports, weights and/or any other applicable monitoring tools monthly for 3 consecutive months, then quarterly for 3 consecutive quarters.**	

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A 069	Continued From page 35 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 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	A 069		

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A 069	Continued From page 36 (f) any other individual in accordance with applicable state and local laws. E. Assessments and reevaluations. (1) An assessment shall be completed by a 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	A 069		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	4107	A. BUILDING: _____ B. WING _____	C 07/27/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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A 069	Continued From page 37 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 (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	A 069		

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A 069	Continued From page 38 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 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 15 (R #s 1 through 15) memory care residents identified on the resident census list provided by the Administrator on 07/14/21, to be at risk of harm or injury if DCS have not received training on the proper methods of providing care and services.	A 069		

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A 069	Continued From page 39 The findings are: A. Record review of staff training files for DCS #s 1, 2 and 5 revealed the following: 1. DCS #1 only had 1.5 hours of training related to Alzheimer's or dementia. 2. DCS #2 had zero (0) hours of training related to Alzheimer's or dementia. 3. DCS #5 had only 10.5 hours of training related to Alzheimer's or dementia. B. On 07/16/21 at 2:30 pm, during an interview with the Administrator and the Resident Care Coordinator, they confirmed that DCS #s 1, 2 and 5 had not completed the required twelve (12) hours of training per year related to Alzheimer's or dementia.	A 069		