

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 4102	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 01/08/2025
NAME OF PROVIDER OR SUPPLIER HAVEN CARE - COTTONWOOD HOUSE		STREET ADDRESS, CITY, STATE, ZIP CODE 5305 QUEENS CT NE ALBUQUERQUE, NM 87109		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
8 000	Initial Comments The following deficiencies were cited during a Complaint survey completed on 01/08/25 for the state requirements of NMAC 8.370.14, Regulations for Assisted Living for Adults. Census: [REDACTED] Complaint intake [REDACTED] was investigated with deficiencies cited.	8 000	8 000 Administrator will comply with pre-employment requirements DA Full employee Abuse registry will performed and completed prior to hire. For every new hire at Havencare	2/28/25
8 016	8 NMAC 370.14.16 Staff Qualifications A facility shall employ staff with the following qualifications: A. Administrator, director, operator: an assisted living facility shall be supervised by a full-time administrator. Multiple facilities that are located within a 40-mile radius may have one full-time administrator. The administrator shall: (1) be at least 21 years of age; (2) have a high school diploma or its equivalent; (3) comply with the requirements of the New Mexico caregivers criminal history screening act, 8.370.5 NMAC; (4) complete a state approved certification program for assisted living administrators; (5) be able to communicate with the residents in the language spoken by the majority of the residents; (6) not work while under the influence of alcohol or illegal drugs; (7) have evidence of education and experience to prove the ability to administer, direct and operate an assisted living facility; the evidence of education and experience shall be directly related to the services that are provided at the facility; (8) provide three notarized letters of reference from persons unrelated to the applicant; and (9) comply with the pre-employment requirements	8 016	② Administrator will ensure all new direct staff submit an application and finger prints to CCHSP no later than 20 days of hire. 3) Once a Final clearance letter has been received, new hires can start training. ④ Administrator will ensure and monitor	2/28/25

Division of Health Improvement

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

TITLE

(X8) DATE

Danitra Sweeney

Administrator

2/28/2025

STATE FORM

5700

8C2J11

If continuation sheet 1 of 15

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 4102	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 01/08/2025
NAME OF PROVIDER OR SUPPLIER HAVEN CARE - COTTONWOOD HOUSE		STREET ADDRESS, CITY, STATE, ZIP CODE 5305 QUEENS CT NE ALBUQUERQUE, NM 87109			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
8 016	Continued From page 1 pursuant to the employee abuse registry, 8.370.8 NMAC. B. Direct care staff: (1) shall be at least 16 years of age; (2) shall have adequate education, relevant training, or experience to provide for the needs of the residents; (3) shall comply with the pre-employment requirements pursuant to the Employee Abuse Registry, 8.370.8 NMAC; and (4) shall comply with the current requirements of reporting and investigating incidents pursuant to incident reporting, intake processing and training requirements, 8.370.9 NMAC; (5) if a facility provides transportation for residents, the employees of the facility who drive vehicles and transport residents shall have copies of the following documents on file at the facility: (a) a valid New Mexico driver's license with the appropriate classification for the vehicle that is used to transport residents; (b) documentation of training in transportation safety for the elderly and disabled, including safe vehicle operation; (c) proof of insurance; and (d) documentation of a clean driving record; (6) any person who provides direct care who is not employed by an agency that is covered by the requirements of the caregivers criminal history screening requirements, 8.370.5 NMAC, shall provide current (within the last 6 months) proof of the caregiver's criminal history screening to the facility; the facility shall maintain and have proof of such screening readily available; and (7) employers shall comply with the requirements of the caregivers criminal history screening requirements, 8.370.5 NMAC. [8.370.14.16 NMAC - N, 7/1/2024]	8 016	All new Applicants have completed all steps prior to training or employment.		2-28-2025

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 4102	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 01/08/2025
---	---	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

HAVEN CARE - COTTONWOOD HOUSE

5305 QUEENS CT NE
ALBUQUERQUE, NM 87109

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
8 016	Continued From page 2 This REQUIREMENT is not met as evidenced by: 8.370.14.16 B (3) (6) Refer to 8.370.8 EMPLOYEE ABUSE REGISTRY 8.370.8 REGISTRY ESTABLISHED; PROVIDER INQUIRY REQUIRED. Upon the effective date of this rule, the department has established and maintains an accurate and complete electronic registry that contains the name, date of birth, address, social security number, and other appropriate identifying information of all persons who, while employed by a provider, have been determined by the department, as a result of an investigation of a complaint, to have engaged in a substantiated registry-referred incident of abuse, neglect or exploitation of a person receiving care or services from a provider. Additions and updates to the registry shall be posted no later than two (2) business days following receipt. Only department staff designated by the custodian may access, maintain and update the data in the registry. A. Provider requirement to inquire of registry. A provider, prior to employing or contracting with an employee, shall inquire of the registry whether the individual under consideration for employment or contracting is listed on the registry. B. Prohibited employment. A provider may not employ or contract with an individual to be an employee if the individual is listed on the registry as having a substantiated registry-referred incident of abuse, neglect or exploitation of a person receiving care or services from a provider. C. Applicant's identifying information required. In making the inquiry to the registry prior to employing or contracting with an employee, the provider shall use identifying information	8 016		

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 4102	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 01/08/2025
---	---	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

HAVEN CARE - COTTONWOOD HOUSE

5305 QUEENS CT NE
ALBUQUERQUE, NM 87109

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
8 016	Continued From page 3 concerning the individual under consideration for employment or contracting sufficient to reasonably and completely search the registry, including the name, address, date of birth, social security number, and other appropriate identifying information required by the registry. D. Documentation of inquiry to registry. The provider shall maintain documentation in the employee's personnel or employment records that evidences the fact that the provider made an inquiry to the registry concerning that employee prior to employment. Such documentation must include evidence, based on the response to such inquiry received from the custodian by the provider, that the employee was not listed on the registry as having a substantiated registry-referred incident of abuse, neglect or exploitation. E. Documentation for other staff. With respect to all employed or contracted individuals providing direct care who are licensed health care professionals or certified nurse aides, the provider shall maintain documentation reflecting the individual's current licensure as a health care professional or current certification as a nurse aide. F. Consequences of noncompliance. The department or other governmental agency having regulatory enforcement authority over a provider may sanction a provider in accordance with applicable law if the provider fails to make an appropriate and timely inquiry of the registry, or fails to maintain evidence of such inquiry, in connection with the hiring or contracting of an employee; or for employing or contracting any person to work as an employee who is listed on the registry. Such sanctions may include a directed plan of correction, civil monetary penalty not to exceed five thousand dollars (\$5000) per instance, or termination or non-renewal of any	8 016		

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 4102	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 01/08/2025
NAME OF PROVIDER OR SUPPLIER HAVEN CARE - COTTONWOOD HOUSE			STREET ADDRESS, CITY, STATE, ZIP CODE 5305 QUEENS CT NE ALBUQUERQUE, NM 87109		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
8 016	Continued From page 4 Contract with the department or other governmental agency. [8.370.8.8 NMAC - N, 07/01/2024] 8.370.5.8 CAREGIVER AND HOSPITAL CAREGIVER EMPLOYMENT REQUIREMENTS: ... D. Application: In order for a nationwide criminal history record to be obtained and processed, the following shall be submitted to the department on forms provided by the department. (1) A form containing personal identification which has a photograph of the person and which meets the requirements for employment eligibility in accordance with the immigration and nationality act as amended. A reasonable xerographic copy of a drivers license photograph will suffice under Subsection D of 8.370.5.8 NMAC. (2) A signed authorization for release of information form. (3) Three (3) complete sets of readable fingerprint cards or other department approved media acceptable to the Department of Public Safety and the Federal Bureau of Investigation submitted using black ink. (4) The fee specified by the department for the nationwide and statewide criminal history screening investigation shall not exceed seventy-four (\$74) dollars. Of which, twenty-four (\$24) dollars shall be applied for the federal bureau of investigation nationwide criminal history screening, seven (\$7) dollars shall be applied for the statewide criminal history screening. The remaining application fee shall be applied to cover costs incurred by the Department to support activities required by the Act and these rules. The fees will not be applied to any other activity or expense undertaken by the Department. ...	8 016			

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 4102	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 01/08/2025
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

HAVEN CARE - COTTONWOOD HOUSE

**5305 QUEENS CT NE
ALBUQUERQUE, NM 87109**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
8 016	Continued From page 5 E. Fees: The federal bureau of investigation has a mandatory processing fee with no exceptions. The Department and Department of Public Safety impose a state processing and administrative fee. The fee payment must accompany the fingerprint application, or otherwise be credited to the department prior to or at the same time with the department's receipt of the application documents. The manner of payment of the fee is by bank cashier check or money order payable to the New Mexico Department of Health or other method of funds transfer acceptable to the department. Business checks will be accepted unless the business tendering the check has previously tendered a check to the department unsupported by sufficient funds. Neither cash nor personal checks will be accepted. The fee may be paid by the care provider or by the applicant, caregiver or hospital caregiver. The department will set a fee in addition to the fees imposed by Department of Public Safety and the Federal Bureau of Investigation that will fully and completely cover costs incurred by the department to support activities required by the act and these rules. The fees will not be applied to any other activity or expense undertaken by the department. F. Timely Submission: Care providers shall submit all fees and pertinent application information for all individuals who meet the definition of an applicant, caregiver or hospital caregiver as described in Subsections D, D and K of 8.370.5.7 NMAC, no later than twenty (20) calendar days from the first day of employment or effective date of a contractual relationship with the care provider. G. Maintenance of Records: Care providers shall maintain documentation relating to all employees and contractors evidencing compliance with the act and these rules.	8 016		

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 4102	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 01/08/2025
---	---	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

HAVEN CARE - COTTONWOOD HOUSE

5305 QUEENS CT NE
ALBUQUERQUE, NM 87109

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
8 016	Continued From page 6 (1) During the term of employment, care providers shall maintain evidence of each applicant, caregiver or hospital caregiver's clearance, pending reconsideration, or disqualification. (2) Care providers shall maintain documented evidence showing the basis for any determination by the care provider that an employee or contractor performs job functions that do not fall within the scope of the requirement for nationwide or statewide criminal history screening. A memorandum in an employee's file stating "This employee does not provide direct care or have routine unsupervised physical or financial access to care recipients served by [name of care provider]," together with the employee's job description, shall suffice for record keeping purposes. Based on record review and interview, the facility failed to ensure Direct Care Staff (DCS) were cleared by the Employee Abuse Registry (EAR) prior to hire and ensuring the applicant submitted their application and fingerprints to the Caregivers Criminal History Screening Program (CCHSP) no later than 20 calendar days of hire. These deficient practices could likely result in all residents to be at risk of harm or abuse if residents are being provided care by staff member who may have a previous history of abusing, neglecting, exploiting residents, and may be a convicted felon. The findings are: A. Record review of DCS #1's employee file, revealed the following: 1. DCS #1's date of hire was 01/20/24 2. DCS #1 received their EAR clearance on	8 016		

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 4102	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 01/08/2025
---	---	--	--

NAME OF PROVIDER OR SUPPLIER
HAVEN CARE - COTTONWOOD HOUSE

STREET ADDRESS, CITY, STATE, ZIP CODE
**5305 QUEENS CT NE
ALBUQUERQUE, NM 87109**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (DEFICIENCIES MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
8 016	Continued From page 7 11/14/24. 3. DCS #1's application and fingerprints were not submitted to the CCHSP. B. On 01/08/25 at 10:00 am, during an interview, Administrator #1 confirmed the following: 1. DCS #1 was not cleared from the EAR prior to hire. 2. DCS #1 application and fingerprints were not submitted to the CCHSP.	8 016	8016 Administrator will ensure all incidents of known or unknown origin including abuse, neglect, exploitation are reported to the licensing authority within 24 hours or next business day if it is a holiday. Once report is filed with licensing Authority a 5-day follow-up will also be submitted and completed.	2-28-25
8 032	8 NMAC 370.14.32 Reporting of Incidents A. The facility shall insure that all suspected cases or known incidents of resident abuse, neglect or exploitation are reported in accordance with 8.370.9 NMAC. (1) The facility shall also report any incident or unusual occurrence which has or could threaten the health, safety, or welfare of the residents and staff to the licensing authority complaint hotline within 24 hours or by the next business day, if it is a weekend or a holiday. (2) The facility shall not delay a report to the complaint hotline while an internal investigation is conducted. B. The facility is responsible for conducting and documenting the investigation of all incidents within five business days and shall submit a copy of the investigation report to the licensing authority. A copy of the report and the documentation, including the date and time that it was submitted to the licensing authority, shall be maintained on file at the facility. The investigation shall include the following: (1) a narrative description of the incident; (2) the result of the facility's investigation shall be recorded on the state approved incident report form for the current year, pursuant to 8.370.9	8 032	Administrator will be monitoring about 5 days after a reportable incident to ensure compliance is being met with incident reporting.	2-28-25

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 4102	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 01/08/2025
NAME OF PROVIDER OR SUPPLIER HAVEN CARE - COTTONWOOD HOUSE		STREET ADDRESS, CITY, STATE, ZIP CODE 5305 QUEENS CT NE ALBUQUERQUE, NM 87109			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
8 032	Continued From page 8 NMAC; and (3) plans for further actions in response to the incident. [8.370.14.32 NMAC - N, 7/1/2024] This REQUIREMENT is not met as evidenced by: 8.370.14.32 (A) (1) Based on record review and interview, the facility failed to ensure for (R) of (R) and R resident whose incident reports were reported to the Licensing Authority within 24 hours and an internal investigation and follow up report was submitted within five (5) business days from when an incident occurred. These deficient practices could likely put residents at risk of harm, injury, and death if an incident of abuse or unusual occurrence is not reported to the Licensing Authority. The findings are: R A. Record review of R progress notes dated 07/06/24 at 8:00 pm revealed R pushed R and both of the residents fell to the floor. B. Record review of the facility's internal incident reports for R dated 06/01/24 through 07/31/24 revealed the records did not contain any documentation that the incident was reported to the Licensed Authority. R C. Record review of R progress notes dated 07/06/24 through 07/08/24 revealed on 07/06/24	8 032			

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 4102	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 01/08/2025
NAME OF PROVIDER OR SUPPLIER HAVEN CARE - COTTONWOOD HOUSE		STREET ADDRESS, CITY, STATE, ZIP CODE 5305 QUEENS CT NE ALBUQUERQUE, NM 87109			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
8 032	Continued From page 9 R [REDACTED] incident with R [REDACTED] resulted in a fall by the kitchen. R [REDACTED] sustained a bruise on the left-side of [REDACTED] D. On 01/07/25 at 4:00 pm, during an interview, Administrator #1 confirmed she was aware of the incident involving R [REDACTED] and R [REDACTED] resulting in a fall that occurred on 07/06/24. Administrator #1 completed an internal investigation but had not reported the incident to the Licensing Authority.	8 032	8032 Administrator will ensure that all Direct care staff assist with all medication per Doctor's orders only. 2-28-25 Administrator will also ensure proper training to staff or All staff on documentation if med pass occurs while a resident is discharged or on an acting all medications should be followed by an exception on Residents MAR followed by a notation stating your reasoning for exception. 2-28-25		
8 035	8 NMAC 370.14.35 Medication Administration of medications or staff assistance with self-administration of medications shall be in accordance with state and federal laws. No medications, including over-the-counter medications, PRN (when needed) medications, or treatment shall be started, changed or discontinued by the facility without an order from the physician, physician assistant or nurse practitioner and with entry into the resident's record. A. State board of nursing licensed or certified health care professionals are responsible for the administration of medications. Administration may only be performed by these individuals. B. Facility staff may assist a resident with the self-administration of medications if written consent by the resident is given to the administrator of the facility or the administrator's designee. If the resident is incapable of giving consent, the surrogate decision maker named in accordance with New Mexico law may give written consent for assistance with self-administration of medications. All staff that assist with self-administration of medications shall have successfully completed a state approved assistance with self-administration of	8 035	Administrator will also monitor all medication error for up to 3 months to ensure no issues.		

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 4102	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 01/08/2025
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

HAVEN CARE - COTTONWOOD HOUSE

**5305 QUEENS CT NE
ALBUQUERQUE, NM 87109**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
8 035	Continued From page 10 medication training program or be licensed or certified by the state board of nursing. C. PRN (pro re nada) medication: (1) Physician or physician extender's orders for PRN medications shall clearly indicate the circumstances in which they are to be used, the number of doses that may be given in a 24-hour period and indicate under what circumstances the primary care practitioner (PCP) is to be notified. (2) The utilization of PRN medications shall be reviewed routinely. Frequent or escalating use of PRN medications shall be reported to the PCP. D. Only a licensed nurse (RN or LPN) shall administer any medications or conduct any invasive procedures provided by the following routes: intravenous (IV), subcutaneous (SQ), intramuscular (IM), vaginal or rectal. Only a licensed nurse shall administer non-premixed nebulizer treatments. E. The facility shall have medication reference material that contains information relating to drug interactions and side effects on the premises. Staff that assist in the self-administration of medications shall know interactions or possible side effects that might occur. F. Medications prescribed for one resident shall not be used for another resident. G. Medication assistance record (MAR): For residents who are not independent and require assistance with self-administration, the facility shall have a MAR that documents the details of the residents' medication, including PRN and over-the-counter medication that is assisted with self-administration by qualified staff or administered to the resident by licensed or certified staff. The information in the MAR shall include: (1) the resident's name; (2) any known allergies to medication that the	8 035		

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 4102	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 01/08/2025
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

HAVEN CARE - COTTONWOOD HOUSE

**5305 QUEENS CT NE
ALBUQUERQUE, NM 87109**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
8 035	Continued From page 11 resident has; (3) the name of the resident's PCP or the prescriber of the medication; (4) the diagnosis or reason for the medication; (5) the name of the medication, including the drug product brand name and the generic name; (6) notation if the medication is a schedule II-IV drug; (7) the dosage of the medication; (8) the strength of the medication; (9) the frequency or how often the medication is to be taken or given; (10) the route of delivery for the medication (mouth, eye, ear, other); (11) the method of delivery for the medication (pills, drops, IM injection, other); (12) the date that the medication was started or discontinued; (13) any change in the medication order; (14) pre-medication information (i.e., pulse, respiration, blood pressure, blood sugar) as required by the medication order; (15) the date and time that the medication is self-administered, administered with assistance or is administered; (16) the initials and signature of the person assisting with or administering the medication; (17) the desired results obtained from or problems encountered with the medication (pain relieved, allergic reaction, etc.); (18) any refused dose of medication; (19) any missed dose of medication; and (20) any medication error. H. No medication shall be stopped or started without specific orders from the primary care physician. I. If a resident refuses to take a prescribed medication, it shall be documented and the facility shall report it to the prescriber.	8 035		

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 4102	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 01/08/2025
NAME OF PROVIDER OR SUPPLIER HAVEN CARE - COTTONWOOD HOUSE			STREET ADDRESS, CITY, STATE, ZIP CODE 5305 QUEENS CT NE ALBUQUERQUE, NM 87109		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
8 035	Continued From page 12 J. A suspected adverse reaction to a medication shall be documented on the MAR and reported immediately to the PCP and the resident's surrogate decision maker. If applicable, emergency medical treatment shall be arranged. Documentation of the event shall be kept in the resident's record. K. Prescription medication, other than blister packs and unit dose containers, shall be kept in the original container with a pharmacy label that includes the following: (1) the resident's name; (2) the name of the medication; (3) the date that the prescription was issued; (4) the prescribed dosage and the instructions for administration of the medication; and (5) the name and title of the prescriber. L. Any medication that is removed from the pharmacy container or blister pack shall be given immediately and documented by the staff that assisted with the medication delivery. M. The facility shall report all medication errors to the physician, documentation of medication errors and the prescriber's response shall be kept in the resident's record. N. The facility shall develop and follow a written policy for unused, outdated, or recalled medications kept in the facility in accordance with 16.19.11.10 NMAC. [8.370.14.35 NMAC - N, 7/1/2024] This REQUIREMENT is not met as evidenced by: 8.370.14.35 G(19), H Based on record review and interview, the facility failed to ensure for █(R█ of █(R█ resident that: 1. Medications were not started, changed or discontinued by the facility without an order from the physician.	8 035			

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 4102	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 01/08/2025
---	---	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

HAVEN CARE - COTTONWOOD HOUSE

5305 QUEENS CT NE
ALBUQUERQUE, NM 87109

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
8 035	Continued From page 13 2. Any missed dose of medication was documented on the medication assistance record (MAR). These deficient practices could likely result in residents being over-medicated or under-medicated leading to adverse (harmful) health outcomes. Findings related to no orders for medication: A. Record review of R [REDACTED] face sheet revealed that R [REDACTED] was admitted to the facility on [REDACTED] and had a diagnosis [REDACTED] (this is not an all-inclusive list of [REDACTED] diagnoses). B. Record review of R [REDACTED] resident information sheet dated [REDACTED] revealed a note containing the following handwritten instructions: "med list given by [name of R [REDACTED]] [REDACTED]" C. On 01/07/24 at 4:00 pm during an interview, the Administrator confirmed that R [REDACTED] was administered medications based off the handwritten instructions provided in the resident information sheet. D. Record review of R [REDACTED] hospital medical records with physician orders dated 07/25/24, received from [Name of Hospital Center] revealed R [REDACTED] was admitted to [Name of Hospital Center] on 07/25/24 for [REDACTED] and was not in the facility thereafter. E. Record review of R [REDACTED] Medication Administration Record (MAR) for 07/01/2024, through 07/31/2024, revealed:	8 035		

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 4102	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 01/08/2025
---	---	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

HAVEN CARE - COTTONWOOD HOUSE

5305 QUEENS CT NE
ALBUQUERQUE, NM 87109

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
8 035	Continued From page 14 1. [REDACTED] [REDACTED] was signed out by DCS #1 as given on 7/27/24 and 07/28/24 at 7:00 am. [REDACTED] by mouth in the [REDACTED] was signed out as given by DCS #1 on 7/27/24 at 8:00 am. 3. [REDACTED] [REDACTED] was signed out as given by DCS #1 on 7/27/24. F. On 01/07/24 at 1:55 pm, during an interview, the Administrator confirmed DCS #1 entered R [REDACTED] medication dispensation incorrectly into the MAR and the resident was not in the facility on 07/27/25 and 07/28/25.	8 035		