Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	4047	A. BUILDING: _____ B. WING _____	C 07/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVAMERE AT RIO RANCHO	1000 RIVERVIEW DRIVE SE RIO RANCHO, NM 87124

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 000	Initial Comments The following deficiencies were cited during a Regulation Review Survey and Complaint survey completed on 07/09/24 for the state requirements of NMAC 8.370.14, Regulations for Assisted Living Facilities for Adults. Resident Census: 114 Complaint Intake NM [redacted] was investigation, with deficiencies cited. Complaint Intake NM [redacted] was investigated, with no deficiencies cited.	A 000		
A 022	7 NMAC 8.2.22 Facility Reports, Records, Rules, Policies FACILITY REPORTS, RECORDS, RULES, POLICIES AND PROCEDURES: A. Reports and records. Each facility shall keep the following reports, records, policies and procedures on file at the facility and make them available for review upon request by the licensing authority, residents, potential residents or their surrogate decision makers: (1) fire inspection report; (2) zoning approval; (3) building official approval (certificate of occupancy); (4) a copy of the approved building plans; (5) a copy of the most recent survey conducted by the licensing authority, to include adverse actions or appeals and complaints; (6) for facilities with food establishments/kitchens that require a permit from the local health authority that has jurisdiction, a copy of the current inspection report in accordance with the applicable, municipal, or federal laws and regulations and pursuant to Subsection B of 7.6.2.8 NMAC, regarding kitchen and food	A 022	A-022 – We have both reviewed and updated all our Emergency Procedures and will be updating our Emergency Disaster Plan to comply with NMAC 8.2.22. Our Emergency Disaster Plan will be reviewed at least quarterly by the Executive Director.	11/18/24

Division of Health Improvement
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE [signature] TITLE Executive Director (X6) DATE 10/10/24

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A 022	Continued From page 1 management; if a facility is considered a licensed private home and not required to meet specific requirements by the local health authority, a copy of that determination must also be maintained; (7) where necessary, a copy of the liquid waste disposal and treatment system permit from the local health authority that has jurisdiction; (8) thirty (30) days of menus as planned, including snacks and thirty (30) days of menus as served, including snacks; (9) record of monthly fire drills conducted at the facility and the fire safety evaluation system (FSES) rating, if applicable; (10) written emergency plans, policies and procedures for medical emergencies, power failure, fire or natural disaster; plans shall include evacuation, persons to be notified, emergency equipment, evacuation routes, refuge areas and the responsibilities of personnel during emergencies; plans shall also included a list of transportation resources that are immediately available to transport the residents to another location in an emergency; the emergency preparedness plan shall address two types of emergencies: (a) an emergency that affects just the facility; and (b) a region/area wide emergency; (11) a copy of this rule, Requirements for Assisted Living Facilities for Adults, 7.8.2 NMAC); (12) for facilities with two or more residents (that are not related to the owner), a valid custodial drug permit issued by the NM board of pharmacy, that supervise administration and self-administration of medications or safeguards with regard to medications for the residents; and (13) vaccination records for pets in the facility. B. Reports and records. Each facility shall keep the following reports, records, policies and procedures on file at the facility and make them	A 022		

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A 022	Continued From page 2 available for review upon request by the licensing authority: (1) a copy of the facility license; (2) employee personnel records, including an application for employment, training records and personnel actions: (a) caregiver criminal history screening documentation pursuant to 7.1.9 NMAC; (b) employee abuse registry documentation pursuant to 7.1.12 NMAC; and (3) a copy of all waivers or variances granted by the licensing authority. C. Rules. Prior to admission to a facility a prospective resident or his or her representative shall be given a copy of the facility rules. Each facility shall have written rules pertaining to resident ' s rights and shall include the following: (1) resident use of tobacco and alcohol; (2) resident use of facility telephone or personal cell phone; (3) resident use of television, radio, stereo and cd; (4) the use and safekeeping of residents ' personal property; (5) meal availability and times; (6) resident use of common areas; (7) accommodation of resident ' s pets; and (8) resident use of electric blankets and appliances. D. Policies and procedures. All facilities shall have written policies and procedures covering the following areas: (1) actions to be taken in case of accidents or emergencies; (2) policy and procedure for updating and consolidating the residents current physician or PCP orders, treatments and diet plans every six (6) months or when a significant change occurs, such as a hospital admission;	A 022		

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A 022	Continued From page 3 (3) policy for medication errors; (4) method of staying informed when residents are away from the facility (e.g., sign-out sheets or other record indicating where the resident will be, cell phone contact, etc.); (5) the handling of resident's funds, if the facility provides such services; (6) reporting of incidents, including abuse, neglect and misappropriation of property, injuries of unknown cause, environmental hazards and law enforcement interventions in accordance with 7.1.13 NMAC; (7) reporting and investigating internal complaints; (8) reporting and investigating complaints to the incident management bureau; (9) staff and resident fire and safety training; (10) smoking policy for staff, residents and visitors; (11) the facility's bed hold policy; (12) admission agreement; (13) admission records; (14) resident records including maintenance and record retention if the facility closes; (15) program narrative; (16) resident's rights with regard to making health care decisions and the formulation of advance directives; (17) personnel policies; (18) identifying and safeguarding resident possessions; (19) securing medical assistance if a resident's own physician is not available; (20) staff training appropriate to staff responsibilities; (21) staff training for employees who provide assistance to residents with boarding or alighting from motor vehicles and safe operation of motor vehicles to transport residents;	A 022		

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A 022	Continued From page 4 (22) witnessed destruction of unused, outdated or recalled medication by the facility administrator with the consulting pharmacist present; and (23) mealtimes, daily snacks, menus, special diets, resident ' s personal preference for eating alone or in the dining room setting. [7.8.2.22 NMAC - Rp, 7.8.2.23 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 8.370.14.22 A (10) (b) Based on record review and interview, the facility failed to ensure a complete written emergency disaster plan in the event of a region/area-wide emergency. This deficient practice could likely result in the 114 (R #s 1-114) residents listed on the census provided by the Administrator on 06/24/24 being at risk of possible harm, injury, or death if Direct Care Staff (DCS) and families did not know what to do or where to go if there was a region/area wide emergency disaster that required evacuation. The findings are: A. A record review of the facility's emergency preparedness plan dated 07/02/24 revealed that it did not include a completed evacuation plans for a region/area-wide disaster. B. On 06/27/24 at 11:55 am, during an interview with the Administrator, he confirmed that the	A 022		

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A 022	Continued From page 5 facility's emergency preparedness plan did not include a completed evacuation plan for a region-wide disaster.	A 022		
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. (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]	A 032	A-032 – Reporting of Abuse, Neglect and Exploitation will be reviewed again at the scheduled All Staff meeting for October 10th, 2024. The Executive Director, Director of Health Services, Resident Care Coordinators and Arbor Administrator will report any concerns of abuse, mistreatment, neglect, exploitation, or medication errors in a manner that is compliant with NMAC 7.1.13. New employees will also receive this training during their competensy trainings. All Incident Reports will be reviewed M-F in clinical stand-up. Reportable incidents will be given to the ED along with the 5-day follow-up and placed into the Incident Report binder for reconciliation	11/18/24

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A 032	Continued From page 6 This REQUIREMENT is not met as evidenced by: 8.370.14.32 A (1) B REPORTING OF INCIDENTS: A. The facility shall ensure (to make certain that something shall occur or be the case) that all suspected cases or known incidents of resident abuse, neglect or exploitation are reported in accordance with 8.370.9 NMAC. (1) The facility shall also report any incident or unusual occurrence which has or could threaten the health, safety, or welfare of the residents and staff to the licensing authority complaint hotline within twenty-four (24) hours or by the next business day, if it is a weekend or a holiday. (3) All licensed health care facilities shall ensure that the reporter with direct knowledge of an incident has immediate access to the bureau incident report form to allow the reporter to respond to, report, and document incidents in a timely and accurate manner. B. The facility is responsible for conducting and documenting the investigation of all incidents within five (5) business days and shall submit a copy of the investigation report to the licensing authority. A copy of the report and the documentation, including the date and time that it was submitted to the licensing authority, shall be maintained on file at the facility. Based on record reviews and interviews, the facility failed to ensure for 1 (R #18) of 4 (Rs #15,18,19 and 20) residents who's internal (facility-created) Incident Reports were reviewed for compliance that:	A 032		

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A 032	Continued From page 7 1. The facility reported incidents of suspected abuse that had or could threaten the health, safety, or welfare of the residents and staff to the Licensing Authority within twenty-four (24) hours or by the next business day if it is a weekend or a holiday. 2. Conducted an internal investigation and submitted an investigation follow-up report to the Licensing Authority (LA) within five (5) business days from when an incident occurred. 3. The reporter with the most direct knowledge of the incident assists with the preparing the incident report form. These deficient practices could likely result in the 114 (R #s 1-114) residents listed on the resident census provided by the Administrator on 06/24/24, to be at risk of harm, injury, and/or death if there is suspected abuse and it is not reported to the Licensing Authority. The findings are: A. Record review of complaint intake NM [redacted] received on 03/14/24 revealed, a "Medication technician (MT) (no name provided) also gave a patient (no name provided) eye drops and they were burning, and they were ear drops." The complaint intake did not give a date or any other identifiable information. B. On 07/01/24 at 9:56 am, during an interview, Direct Care Staff (DCS) #15 stated: 1. R #18 told her that a DCS (no name provided) placed ear drops into [redacted] eyes, that caused R #18's eyes to burn and DCS did not rinse R #18's eyes afterward. R #18's could not recall exactly when this happened but that it was reported to [redacted] a few days after the incident occurred. When asked for the timeframe, [redacted] stated it was	A 032		

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A 032	Continued From page 8 "recently," but could not narrow down a date. 2. When asked if she (DCS #15) reported the incident to anyone, she stated, "I was not 100 percent sure the incident had actually occurred, therefore, I did not notify any staff or supervisor nor mention it in a progress note to alert other staff of the possible occurrence." 3. DCS #15 did not report the incident to the Licensing Authority. C. Record review of R #18's file revealed the record did not contain any incident reports, medication errors or progress notes regarding the incident mentioned in complaint intake NM #73154. D. On 06/26/24 at 4:14 pm, during an interview, R #18 stated [redacted] recalled the incident vividly and could identify that DCS #6 "accidentally placed ear drops into [redacted] eyes, causing [redacted] eyes to burn." When asked if [redacted] had received medical attention, [redacted] stated, "No, I endured the evening with my eyes burning until the burning stopped the next day." [redacted] could not recall the exact incident date and stated, "I don't know; I lost track of time, and don't have any idea." E. On 06/28/24 at 2:20 pm, during an interview, DCS #6 stated: " I caught the mistake before ear drops were placed in R #18's eyes, so nothing happened, and that's why I did not make a report or tell anyone. It's just that the ear and eye drop containers look similar, but I caught this before anything happened." F. On 07/01/24 at 1:00 pm, during an interview, the Registered Nurse (RN) Health Services Director stated: "No one told me about the	A 032		

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A 032	Continued From page 9 incident, and I never got a progress note, medication error notice, or incident report mentioning this. If I had known the incident had occurred, I would have ensured facility staff would have rinsed out R #18's eyes and would have filed a report with your department (referencing 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 include the telephone numbers for the incident management hotline and for the state ombudsman program.	A 033	A-033 –Resident's Rights, and the reporting of Abuse, Neglect and Exploitation will be reviewed again at the scheduled All Staff meeting for October 10th, 2024. We will continue to complete background checks and reference checks for all new staff prior to employment. New staff will be educated on Resident's Rights, and the reporting of Abuse, Neglect and Exploitation upon hire. The Executive Director, Director of Health Services, Resident Care Coordinators and Arbor Administrator will immediately report any concerns of abuse, mistreatment, neglect, or exploitation in a manner that is compliant with NMAC 7.1.13 and involve law enforcement as appropriate. We have submitted a proposal for a camera surveillance system to our ownership for consideration in our 2025 capital budget.	11/18/24

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A 033	Continued From page 10 D. To protect resident rights, the facility shall: (1) treat all residents with courtesy, respect, dignity and compassion; (2) not discriminate in admission or services based on gender, sexual orientation, resident's age, race, religion, physical or mental disability, or nationality; (3) provide residents written information about all services provided by the facility and their costs and give advance written notice of any changes; (4) provide residents with a safe and sanitary living environment; (5) provide humane care for all residents; (6) provide the right to privacy, including privacy during medical examinations, consultations and treatment; (7) protect the confidentiality of the resident ' s medical record; (8) protect the right to personal privacy, including privacy in personal hygiene; privacy during visits with a spouse, family member or other visitor; and privacy in the resident's own room; (9) protect the right to communicate privately and freely with any person, including private telephone conversations and private correspondence; and the right to receive visits from family, friends, lawyers, ombudsmen and community organizations; (10) prohibit the use of any and all physical and chemical restraints; (11) ensure that residents: (a) are free from physical and emotional abuse neglect and misappropriation/or exploitation; (b) are free from financial abuse and misappropriation by facility staff or management; (c) are free to participate in religious, social, community and other activities and freely associate with persons in and out of the facility; (d) are free to leave the facility and return without	A 033		

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A 033	Continued From page 11 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 or discharge. E. The resident's rights shall not be restricted unless this restriction is for the health and safety	A 033		

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A 033	Continued From page 12 of the resident, agreed to by the resident or the resident ' s surrogate decision maker and outlined in the resident ' s individual service plan. [7.8.2.33 NMAC - Rp, 7.8.2.34 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 8.370.14.33 D (11) b Based on record review and interview, the facility failed to ensure for 3 (R #s 1, 14 and 23) of 7 (R #s 1, 2, 6, 14, 23, 24, and 25) residents identified by the facility as being at risk of exploitation and were free from financial abuse and misappropriation by facility staff. This deficient practice resulted in the resident experiencing both financial and psychosocial harm resulting from a substantial loss of income. The findings are: Findings for R #1: A. Record review of the Assisted Living Facility (ALF) Damaged and Missing Item Report dated 03/14/24 revealed: 1. R #1 notified the facility that on 03/13/24, [redacted] noticed that [redacted] and the contents, which included [redacted] debit card, and $700.00 United States Dollars (USD) were missing (from [redacted] oom). 2. R #1 reported a man was in [redacted] room (on 03/13/24 when [redacted] didn't remember or know who he was. B. Record review of Complaint Intake [redacted] dated 03/14/24 4:42 am revealed: 1. Incident date 03/13/24 6:00 pm.	A 033		

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A 033	Continued From page 13 2. "Resident stated a man came into clean [redacted] room and cleaned. Resident checked [redacted] (sic) ID, Debit card and $700 were missing." 3. "Resident notified staff and staff searched the roomed to see if it was misplaced. Staff could not locate teh (sic) missing items." C. Record review of Law Enforcement Report [redacted] dated 03/17/24 revealed: 1. The facility reported that R #1's state driver's license, $700.00, credit and debit cards were missing. 2. R #1 told police that on 03/13/24, an employee (DCS #1) wok[redacted] up and was on the side o[redacted]bed, and [redacted]asked what he was doing. He (DCS #1) stated that he was helping to clean up a bit. [redacted]R #1) described him (DCS #1) as male, approximately 5'08-5'10 in height and approximately 200 pounds. 3. Police [redacted] interviewed several DCS who were working the prior evening and police were told (by various unknown DCS interviewed) that DCS #1 was working. 4. Police [redacted] contacted R #1's Power of Attorney (POA), and POA stated that she (POA) was advised by the bank that an unknown person had attempted to withdraw $2000.00 at a local casino on 03/13/24 at 11:44 pm and that there was an attempt to withdraw $500.00 twice from an Automated Teller Machine (ATM) on 03/14/24 at 8:38 pm. 5. On 03/19/24, DCS #1 was apprehended (arrested) by law enforcement authorities concerning an on going investigation tied to theft at the facility. 6. During an interview with DCS #1 by police [redacted] on 03/19/24, the police reported "[First name of DCS #1] confessed to discovering a discarded debit card in the "trash" inside [First	A 033		

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name of R #1's] room and subsequently attempting to utilize it at both a [name of bank] ATM and [name of casino]."

7. Evidence supplied by the local casino and bank led to the arrest of DCS #1, who confessed to unlawfully using R #1's debit card.

D. Record review of the local magistrate court case [redacted] criminal complaint revealed DCS #1 was charged with:

1. Count 1: 1.1. Unauthorized withdrawal, theft, and use of the card of another. Contrary (illegal) to section: 58-16-16(B) New Mexico Statutes Annotated (NMSA) 1978.

2. Count 2: Theft of identity; obtaining identity by electronic fraud. Contrary to Section: 30-16-24.1 (A)(2) NMSA 1978.

3. Count 3: Larceny (over $500 United States Dollars [USD], but not more than $2500.00 USD): 4th-degree felony [more serious than misdemeanor {minor wrongdoing} and punishable by imprisonment]). Contrary to section 30-16-1D NMSA 1978.

4. On 03/13/24 through 03/14/24, DCS #1 fulfilled his duties as a caregiver at the facility, and during his shift, he unlawfully appropriated (took) possessions (property and money) from a [redacted]owned by R #1, who is a resident of the facility where DCS #1 worked.

5. On 03/19/24, DCS #1 was arrested by law enforcement authorities in connection with an ongoing investigation tied to an incident.

E. Record review of DCS #1's punch card report (actual time worked [when DCS punched in and out]) dated 03/14/24 revealed that DCS #1 worked on 03/14/24 from 4:12 pm through 9:55 pm.

F. On 07/01/24 at 3:25 pm, during an interview

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with R #1's granddaughter, she stated that:
1. Since the theft of [redacted] R #1's) money and debit card, [redacted] #1) is very distressed.
2. She (granddaughter to R #1) has noticed a change in R #1's personality.
3. Every time she (granddaughter to R #1) talks to R #1, it's as if the incident just happened and, R #1 doesn't stop talking about it.
4. R #1 is anxious now and is always on guard.

Findings for R #14:

G. Record review of the ALF Damaged/Missing Item report dated 03/12/24 revealed that R #14's:
1. The [redacted] wallet, glasses, and $80 in cash was stored in [redacted] dresser drawer.
2. On the morning of Friday, 03/08/24, [redacted] noticed tha[redacted] was missing.
3. R #14 stated that [redacted] thought the person who got a T-shirt fo[redacted] to wear took [redacted]

H. Record review of the 5-day FUR for complaint intake #73136 incident date 03/08/24, revealed that:
1. On 03/08/24, R #14 reporte[redacted] wallet containing $80.00 in cash, debit card, and glasses went missing.
2. There was a $45 charge or[redacted] debit card at a Mexican fast-food restaurant.

I. Record review of Law Enforcement report [redacted] (dated 03/12/24) revealed:
1. R #14's [redacted] which contained [redacted] wallet, debit card and $80.00 cash was missing.
2. R #14's Power of Attorney (POA) notified R #14's bank, and the bank report revealed that a transaction was completed at a Mexican

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restaurant on 03/07/24 for $45.80.

3. A receipt from the Mexican restaurant revealed a mobile order on 03/07/24 at 11:10 pm for $45.80 charged to R #14's debit card.

4. A receipt from the Mexican restaurant identified DCS #1's (first name: nickname) and [redacted]last name.

5. DCS #1 confessed to law enforcement that he struggled financially, is homeless, and has taken desperate measures to survive.

6. DCS #1 confessed that he placed an order at the restaurant on 03/07/24 at 11:10 pm in the amount of $45.80, using a card that did not belong to him.

7. DCS #1 confessed that he found a credit card in the trash and used it to try and withdraw money at a casino, at R #14's bank, and to make a purchase on a social media platform to "test" the card.

J. A record review of the local magistrate amended criminal complaint (case [redacted] revealed:

1. A debit card receipt dated 03/07/24 at 11:10 pm, from a Mexican restaurant for two (2) "fiesta packs" and two (2) "macho drinks" in the amount of $45.80. The receipt also revealed DCS #1's first and last name on top.

2. Surveillance video (dated 03/07/24 at 11:17 pm) of the restaurant revealed a silver passenger car with silver-taped side and rear windows pulled into the driveway at 23:17 hours (11:17 pm). At 11:23 pm, DCS #1 received 2 fiesta packs and 2 macho drinks (these items matched the receipt).

3. On 03/18/24, a police officer located a vehicle matching the vehicle's description on the restaurant's surveillance video (taken on 03/07/24 at 11:17 pm) at the ALF parking lot where DCS #1 works. The police officer observed DCS #1 next to the car and took a photo of him next to the

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car. The police officer conducted a motor vehicle division (MVD) query (computer search) of the vehicle, and it returned a vehicle that identified the vehicle plates registered in the name of DCS #1.

4. The conclusion statement stated that DCS #1's actions have resulted in financial and property loss, highlighting the disrespect for the clients he served at the ALF where he worked. DCS #1 was still employed at the ALF and posed a threat to other clients at the ALF, underscoring (draw attention to) the need for his swift apprehension (arrest) to prevent further crimes within the ALF. The police officer requested an arrest warrant be issued for DCS #1 for unauthorized withdrawal, theft, use of the card of another (R #14), theft of identity, and larceny.

K. Record review of law enforcement Advice of Rights case numbe[redacted] dated 03/19/24 at 15:50 [3:50 pm]) revealed that DCS #1 initialed and dated the waiver of his rights and agreed to answer questions after his arrest by the local police officer[redacted]

L. On 06/26/24 at 3:16 pm, during an interview with R #14[redacted] stated that:

1. One day (date unknown), R #14 stated that DCS #1 got[redacted] shirt from[redacted] second dresser drawer on the right side, and in the process of removing the shirt, it exposed[redacted] R #14 saw DCS #1 from[redacted] peripheral vision (what you can see to each side or up and down without moving your head) and could not identify him.

2. R #14 stated the same DCS #1 came in and took another shirt from the same drawer.

3. R #14 stated that the next day,[redacted] went to get[redacted] to go shopping, and it was gone. R #14 stated that on the same day[redacted] son (POA)

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A 033	Continued From page 18 called to le [redacted] that the bank notified him that somebody attempted to withdraw $100 from R #14's credit card, but the bank declined it. Her son/POA also stated that the same person went to a Mexican restaurant drive-thru and charged $46.00 for food on R #14's debit card (this transaction went through). 4. R #14 stated that $86.00 of cash was also taken from [redacted] M. On 07/01/24 at 1:21 pm, during an interview with R #14's son/POA, he confirmed the following: 1. He received a notification from R #14's bank that two (2) attempts to use [redacted] (R #14's) debit card were made: the first one was on 03/07/24 (attempted to purchase a $100 pay card, and the bank declined it) and the second transaction was for food at a Mexican restaurant, and the $45.00 transaction went through. 2. He stated that the ALF Executive Director (ED) contacted the police right away, and the police eventually arrested DCS #1, an employee at the facility. N. On 07/08/24 at 1:46 pm, during an interview with DCS #1, he stated: 1. He was employed as a caregiver at the facility from the end of February 2024 through March 19, 2024, and his standard shift was from 2:00 pm to 10:00 pm. 2. His role was to change and turn residents, do their laundry, and deliver food to them or take them to the dining hall. 3. DCS #1 stated that he left because he was arrested for a warrant, and he said that he didn't know what the warrant was for. Findings for R #23:	A 033		

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A 033	Continued From page 19 O. Record review of Complaint Intake [redacted] and 5-day FUR (Incident date 03/16/24), revealed: 1. R #23 reported $50.00 and [redacted]bit card was missing. There was a $12.00 charge to [redacted] (R #23's) debit card. 2. The theft was reported to the local police (case [redacted]. 3. The ED of the facility concluded that the financial exploitation/misappropriation of funds occurred. 4. Since the former employee DCS #1 was arrested, there have been no reported thefts. P. Record review of the Law Enforcement report [redacted]evealed: 1. Police officer [redacted]responded to a fraud call at the facility, and he went to the facility to investigate the report. 2. R #23 and [redacted]POA were interviewed by the Police office[redacted]and they informed the police officer that R #23's debit card, $53.00 USD, and [redacted]surance card were missing from [redacted]wallet. 3. R #23 stated that [redacted] lef[redacted]dirty laundry in a basket outside [redacted]loor on 03/14/24. 4. R #23 informed the police officer [redacted] tha[redacted]debit card had been used to make an online purchase from an online social media platform for $11.83. 5. On 03/19/24, DCS #1 was apprehended by law enforcement and DCS #1 confessed to "testing" R #23's debit card by making a purchase online to see if it worked. Q. Record review of the local magistrate criminal complaint (case[redacted]revealed that DCS #1 was charged with: 1. Count 1: Unauthorized withdrawal, theft, use of the card of another. Contrary to section:	A 033		

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A 033	Continued From page 20 58-16-16 (B) NMSA 1978. 2. Count 2: Theft of identity: obtaining identity by electronic fraud. Contrary to section: 30-16-24.1 (A)(2) NMSA 1978. 3. Count 3: Larceny. Contrary to section: 30-16-1 (B) NMSA 1978. 4. On 03/15/24 at 5:06 pm, officers were dispatched to the facility as a response to a fraud call by the facility. Upon arrival at the facility, officers interviewed R #23 an[redacted]daughter/POA. They reported that R #23's debit card, insurance card, and $53.00 were missing from [redacted]R #23's) wallet. 5. On 03/19/24, DCS #1 was apprehended by law enforcement and he (DCS #1) confessed to "testing" R #23's debit card for $11.83, by making a purchase on an online social media platform to see if it worked. R. Record review of R #23's 03/15/24 bank statement revealed a purchase of $11.83 was made online. S. On 06/27/24 at 10:55 am, during an interview with the facility ED, he confirmed that: 1. DCS #1 was employed by the facility from 02/21/24 through 03/19/24. 2. Several residents, including R #1, R #14, and R #23 had reported missing cash, debit cards, credit cards, insurance cards during the month of 03/2024 and DCS #1 unlawfully stole cash and unlawfully charged the residents debit and credit cards. 3. The ED reported the thefts to the local police department and officers responded and investigated the complaints. 4. DCS #1 was arrested on 03/19/24 for the above mentioned charges, and DCS #1 was terminated from the facility on the same day.	A 033		

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A 035	Continued From page 21 7 NMAC 8.2.35 Medication MEDICATIONS: 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 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	A 035	Type text here	
A 035		A 035	Type text here A035- Medication administration will be reviewed again at the scheduled clinical staff meeting on October 10th, on 2024. Residents will be encouraged to take their medications at the times they are scheduled. If refused, the non-narcotic medication will be put into bio bags to be picked up by steri-cycle and narcotics will be destroyed in Rx destroyer by RN. RCC/RN/designee will conduct randomized room checks and med cart audits for 60 days. Findings will be discussed at the following CQI meeting for further review if necessary.	11/18/24

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A 035	Continued From page 22 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 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	A 035		

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A 035	Continued From page 23 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. 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:	A 035		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 035	Continued From page 24 (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 (AS AMENDED). [7.8.2.35 NMAC - Rp, 7.8.2.35 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 8.370.14.35 L Based on observation, record review, and interview, the facility failed to ensure that all medications, including non-prescription drugs, removed from a pharmacy container or blister pack were given immediately after being removed from the pharmacy container or bubble pack. This deficient practice could likely result in the 114 (R #s 1-114) residents listed on the resident census provided by the Executive Director (ED) on 06/24/24, to be at risk of illness, harm, or death if :	A 035		

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A 035	Continued From page 25 1. Medications are not taken immediately after being removed from the resident's pharmacy bottle or bubble pack. 2. Medication errors occur if other residents go into the resident's room and take unsecured medications not prescribed to them. The findings are: A. On 06/26/24 at 10:02 am, during an observation of R #1's room, there were five and a half (5 1/2) unknown medications (one blue capsule, one white capsule, one yellow tablet, two white oval-shaped tablets and half of a white oval-shaped tablet) in a cup near R #1's breakfast plate. B. Record review of R #1's resident file revealed the record did not contain a physician's order allowing R #1 to self-manage her medications. C. On 06/27/24 at 10:02 am, during an interview with R #1, she stated that Direct Care Staff (DCS) normally leav[redacted] morning medications near[redacted] food becaus[redacted] must take[redacted] medications after eating breakfast. D. On 06/27/24 at 3:45 pm, during an interview with the Director of Health Services, she confirmed that R #1's did not take[redacted] medication immediately after it was removed from [redacted] pharmacy bottle or bubble pack and that medication errors could occur if other residents went into the resident's room and took the unsecured medications that were not prescribed to them.	A 035		
A 036	7 NMAC 8.2.36 Nutrition	A 036		

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A 036	Continued From page 26 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 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	A 036	A-036 – We will ensure that snacks of nourishing quality are freely available all day, and that it is posted on our "Always Available" Menu to comply with NMAC 8.2.36. A documented in-service training will be conducted by the Director of Dining Services to educate the dietary team on food storage (labeling and dating) procedures and the use of temp logs for all coolers, freezers, steam table, and dishwasher. New hires will be trained on food storage (labeling and dating) procedures and the use of temp logs for all coolers, freezers, steam table and dishwasher upon hire. The Director of Dining Services will verify weekly that all temp logs are signed off and that all stored food is properly labeled and dated. The Executive Director will conduct a kitchen audit as part of our monthly CQI (Continuous Quality Improvement) meetings.	11/18/24

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A 036	Continued From page 27 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 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.	A 036		

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A 036	Continued From page 28 (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 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.	A 036		

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A 036	Continued From page 29 (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 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,	A 036		

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A 036	Continued From page 30	A 036		

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 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

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A 036	Continued From page 31 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: 8.370.14.36 A(d) B (4) C (2) (d) and D(3) Based on observation, record review, and interview, the facility failed to ensure: 1. The weekly menu posted for residents included a choice of snacks. 2. There was a daily log of the recorded temperatures for all facility refrigerators, freezers and steam table. 3. There was a monthly log of the recorded temperature of the dishwasher. 4. Food stored in the refrigerator was covered, dated, and labeled. These deficient practices could likely result in the 114 (R #s 1-114) residents listed on the census provided by the Administrator on 06/24/24, to be at risk of harm if: 1. The residents were to contract foodborne illnesses if food was not covered, dated or labeled and the temperatures of the freezer, refrigerator, or dishwasher were not accurate. 2. The resident was unaware of option for snacks. Findings for unlabeled, undated, and uncovered items:	A 036		

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A 036	Continued From page 32 A. On 06/25/24 at 10:00 am, during observation of the kitchen, the following items were found in the walk-in refrigerator: 1. Two (2) undated and unlabeled large pieces of raw meat stored in metal pans (unknown size). 2. One (1) 5.5-quart (qt.) opened and undated container of cheese. 3. One (1) 7-qt. opened, undated, and unlabeled container of unknown red sauce. 4. One (1) 64-ounce (oz.) opened and undated juice drink. 5. One (1) 7-qt. opened, undated, and unlabeled. 6. One (1) 5-gallon (gal.) opened undated cream. 7. One (1) 16-oz. opened and undated container of broth. 8. One (1) 8-pound (lb.) opened and an undated container of salsa. 9. One (1) 1-gal. opened and an undated container of jalapeno's. 10. Four (4) 1-gal. opened and undated containers of salad dressing. 11. One (1) 1-gal. opened and an undated container of tartar sauce. 12. One (1) 1-gal. opened and an undated container of hot sauce. 13. One (1) 5-lbs. opened and an undated container of cottage cheese. 14. One (1) 1-gal. opened and an undated container of horseradish sauce. of horseradish sauce. B. On 06/25/24 at 10:10 am, during an observation of the kitchen, the following items were found in the walk-in freezer: 1. One (1) 20 lbs. opened and undated bag of hamburger patties. 2. One (1) 1-gal. opened and undated bag of	A 036		

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A 036	Continued From page 33 pepperoni. 3. One (1) 20 lbs. opened and undated bag of unknown meat patties. 4. One (1) 1-gal. opened and undated bag of frozen green beans. 5. One (1) 30 lbs. opened and undated bag of frozen corn. C. On 06/25/24 at 10:20 am, during an observation of the kitchen, the following items were found in the walk-in dry pantry: 1. One (1) large uncovered, opened, and undated container of sugar. 2. One (1) large uncovered, opened, and undated flour container. 3. One (1) 5-lb. undated container of peanut butter. 4. One (1) 13-oz. opened and undated bag of chips. 5. One (1) 160-oz. opened and an undated bag of raw spaghetti noodles. 6. One (1)138-oz. opened and an undated container of salsa. 7. One (1) 2.5-lbs. opened and an undated bag of cookies. 8. One (1) 10-oz. opened and an undated bag of white chocolate pieces. 9. One (1) Large opened and an undated bag of tortilla chips. 10. One (1) 1-pint (pt.) opened and an undated bag of almonds. D. Record review of the kitchen dishwasher log, staff did not complete the temperature logs for the months of May 2024 and June 2024. E. Record review of the kitchen freezer temperature log revealed staff did not complete entries for the following days in June 2024: 1. June 1 through 2, 2024.	A 036		

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A 036	Continued From page 34 2. June 7 through 9, 2024. 3. June 14 through 16, 2024. 4. June 20 through 24, 2024. F. Record review of the weekly menu revealed the weekly menu did not list any snacks for the week. G. On 06/25/24 at 10:52 am, during an interview with the Kitchen Manager, she confirmed the following: 1. The opened, undated, unlabeled food items in the refrigerator, freezer, and pantry. 2. The incomplete dishwasher log. 3. The missing entries in the freezer log. H. On 06/27/24 at 11:55 am, during an interview with the Dietary Manager, he confirmed snacks were not listed on the menu.	A 036		
A 038	7 NMAC 8.2.38 Housekeeping Services HOUSEKEEPING SERVICES. The facility shall maintain the interior and exterior of the facility in a safe, clean, orderly and attractive manner. The facility shall be free from offensive odors, safety hazards, insects and rodents and accumulations of dirt, rubbish and dust. A. All common living areas and all bathrooms shall be cleaned as often as necessary to maintain a clean and sanitary environment. B. Combustibles such as cleaning rags or flammable substances shall be stored in closed metal containers in approved areas that provide adequate ventilation. Combustibles shall be stored away from the food preparation areas and away from the resident rooms. C. Poisonous or flammable substances shall not be stored in residential areas, food preparation	A 038	A-038-Cleanliness of resident rooms will be reviewed daily during the clinical meetings and housekeeping will be notified if further clean up is needed after these reviews. Proper Disposal of soiled briefs, chucks, wipes, and PPE procedures will be discussed at all shift crossovers: 6am, 2pm, & 10pm. Med techs will include this process review in their shift communication log.	11/18/24

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A 038	Continued From page 35 areas or food storage areas. If hazardous chemicals are stored on the property, material safety data sheets shall be maintained and stored in the same area as the chemicals, pursuant to state environment department requirements, 11.5.2.9 NMAC. [7.8.2.38 NMAC - Rp, 7.8.2.39 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 8.370.14.38 A. Based on observation and interviews, the facility failed to ensure the facility was maintained in a clean and sanitary manner. This deficient practice could likely result in the 114 (R #s 1-114) residents listed on the resident census provided by the Executive Director on 06/24/24 to be at risk of harm, illness, or injury if the residents come into contact with bacteria from unsanitary rooms or bathrooms. The findings are: A. On 06/27/24 at 3:59 pm, during observation of R #15 room revealed: 1. One (1) wastebasket overflowing with urine-soaked bed pads and incontinence briefs located next to the resident's bed. 2. Used latex gloves was thrown on the floor of R #15 bedroom (carpet) floor. 3. A paper towel with a dried substance thrown on the resident's bedroom (carpet) floor. 4. Urine odor emanated (gave out) from the overflowing waste basket. B. On 06/27/24 at 3:59 pm, during an interview, R	A 038		

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A 038	Continued From page 36 #15 stated, "Mostly during night shift, my soiled briefs are not changed as frequently in comparison to day shift, and I will lay in soiled briefs until the next day. They rarely clean my room, and the wastebasket is usually full of used briefs." C. On 07/01/24 at 1:00 pm, during an interview with the RN-Director of Health Services, the RN confirmed that the wastebasket overflowed with urine-soaked bed pads, incontinence briefs, and a used pair of latex gloves tossed on the carpet along with a paper towel with a dried substance.	A 038		
A 042	7 NMAC 8.2.42 Maintenance of Building and Grounds MAINTENANCE OF BUILDING AND GROUNDS: The building(s) shall be maintained in good repair at all times. Such maintenance shall include, but is not limited to, the following areas: A. Storage areas/grounds. Storage areas and grounds shall be maintained in a safe, sanitary and presentable condition at all times. Storage areas and grounds shall be kept free from accumulation of refuse, weeds, discarded furniture, old newspapers or other items that create a fire hazard. B. Floors. Floors shall be maintained stable, firm and free of tripping hazards. [7.8.2.42 NMAC - Rp, 7.8.2.43 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 8.370.14.42 Based on observation and interview, the facility	A 042	A-042—All damaged and discolored ceiling tiles, specifically outside rooms 116, 118, 214, 220, 232, and 234 have been replaced. The damaged/discolored ceiling tile outside the first-floor medication room has been replaced. The damaged or bent screens have been replaced in the following rooms: 102, 136, MC21. The three screens in the last three windows of the MCU activity area and the screen in the MC office have also been replaced. We have contracted a glass company to repair/replace screens in the following apartments: 218, 238. The vendor is scheduled to come out on 10/7 to take measurements for the screens. In addition to the screens, vendor will replace the broken pane of glass on the eighth window above the main dining hall. The broken blinds in MC12 have been replaced.	11/18/24

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A 042	Continued From page 37 failed to ensure: 1. The building was maintained in good condition at all times. 2. The grounds were kept free of accumulation of trash. 3. The windows were in good repair. 4. The facility had blinds on the windows that were in good repair. These deficient practices could likely result in the 114 (R #s 1-114) residents listed on the resident census, provided by the Administrator on 06/24/24, to be at risk of harm if the facility is not in good repair and free of environmental hazards or illness and/or injury if the residents are subjected to insects, rodents, dust or debris entering through the bent frames, torn or missing window screens. . The findings are: A. On 06/24/24 at 3:01 pm, during an observation of the interior of the facility, ceiling tiles were damaged and discolored in the following areas: 1. Outside of resident rooms 116 and 118 2. Outside of resident room 214. 3. Outside of resident room 220. 4. Outside of the first-floor medication room. 5. Outside of resident rooms 232 and 234. B. On 06/26/24 at 8:00 am, during observation of the exterior of the facility revealed the following: 1. The eighth window above the main dining hall had a cracked across the window pane. 2. A wooden picket (wood fence boards nailed together) on the north-facing fence enclosing the Memory Care unit (MCU) was broken. 3. A wooden picket on the north-facing fence enclosing the MCU was missing.	A 042	A 042 continued from page 37 The broken and missing pickets on the fence enclosing the Memory Care Unit have been repaired. Staff will be encouraged to identify any safety/maintenance concerns and enter a work order into our TELS preventative maintenance system. The Executive Director will walk the entire campus weekly to identify any maintenance issues and ensure timely correction to remain compliant with NMAC 8.2.42	

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A 042	Continued From page 38 4. The single window in resident room 102 had a bent screen. 5. The single window in resident room 136 had a bent screen. 6. The single window in resident room 218 had a damaged torn screen. 7. The single window in resident room 238 had a damaged torn screen. 8. The single window in MCU #21 resident room B had a bent screen. 9. The last three windows in the MCU activity area (across from the TV room) had bent screens. C. On 06/26/24 at 8:05 am, during observation near the kitchen walkway on the east side of the facility, food wrappers and paper trash were discarded on the ground. D. On 06/26/24 at 10:45 am, during an interview, the Maintenance Supervisor confirmed: 1. The damaged and missing wooden fence pickets. 2. The damaged and discolored ceiling tiles. 3. The trash on the east side near the kitchen walk path. 4. That a window above the main dining hall was cracked. 5. That the window screens listed above were either torn, damaged, or had a bent frame. E. On 06/26/24 at 4:05 pm, during an observation of the facility, ten of the panels of the blinds on the window in the MCU resident room #12 was found to be broken. F. On 06/26/24 at 4:30 pm, during an interview, Direct Care Staff (DCS) #14 confirmed the broken blinds in MCU room #12, and she said a "maintenance request was submitted at least a	A 042		

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A 042	Continued From page 39 month ago."	A 042		
A 059	7 NMAC 8.2.59 Windows WINDOWS: A. Each sleeping room shall be provided with an exterior window. (1) The window shall be operable, screened and have a clear operable area of 5.7 square feet minimum; measured twenty (20) inches wide minimum and measured twenty-four (24) inches high minimum. (2) The top of the window sill shall not be more than forty-four (44) inches above the finished floor. B. Screens shall be provided on all operable windows. C. The proposed use of bars, grilles, grates or similar devices shall be reviewed and approved by the licensing authority prior to installation. D. Sleeping rooms, living rooms, activity room areas and dining room areas shall have a window area of at least one tenth (1/10) of the floor area with a minimum of ten (10) square feet. [7.8.2.59 NMAC - Rp, 7.8.2.52 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 8.370.14.59 B Based on observation and interview, the facility failed to ensure that all operable windows had screens. This deficient practice could likely result in the 114 (R #s 1-114) residents identified on the census provided by the Administrator on 06/24/24, to be at risk of illness and/or injury if the residents are subjected to insects, rodents, dust	A 059	A-059—The missing screens have been replaced in the following rooms: 206, 212, 218, MC12, MC21, MC25. The screen in the MCU office has also been replaced. We have contracted a vendor to replace the screens in the following rooms: 204, 210, 236. Glass vendor will be here on 10/7 to take measurements for replacement screens. The ED will walk the entire campus weekly to identify any maintenance issues and ensure timely correction to remain compliant with NMAC 8.2.59	11/18/24

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A 059	Continued From page 40 or debris entering through the missing window screens. The findings are: A. On 06/26/24 at 8:00 am, during an observation of the exterior of the facility revealed the following: 1. The single window in resident room 204 did not have a screen. 2. The left pane of the double window in resident room 206 did not have a screen. 3. The single window in resident room 210 did not have a screen. 4. The right pane of the double window in resident room 210 did not have a screen. 5. The left pane of the double window in resident room 212 did not have a screen. 6. The right pane of the double window in resident room 218 did not have a screen. 7. The left and right pane of the double window in resident room 236 did not have screens. 8. The single window in the Memory Care Unit (MCU) #12 resident room did not have a screen. 9. The single window in MCU #21 resident room A did not have a screen. 10. The single window in MCU #25 resident room A did not have a screen. 11. The window in the MCU admin office did not have a screen. B. On 06/26/24 at 10:45 am, during an interview, the Maintenance Supervisor confirmed that the window screens were missing.	A 059		
A 063	7 NMAC 8.2.63 Fire Extinguishers	A 063		

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A 063	Continued From page 41 FIRE EXTINGUISHERS: Fire extinguisher(s) must be located in the facility, as approved by the state fire marshal or the fire prevention authority with jurisdiction. A. Facilities must as a minimum have two (2) 2A10BC fire extinguishers: (1) one (1) extinguisher located in the kitchen or food preparation area; (2) one (1) extinguisher centrally located in the facility; (3) all fire extinguishers shall be inspected yearly and recharged as needed; all fire extinguishers must be tagged noting the date of the inspection; (4) the maximum distance between fire extinguishers shall be fifty (50) feet. B. Fire extinguishers, alarm systems, automatic detection equipment and other fire fighting equipment shall be properly maintained and inspected as recommended by the manufacturer, state fire marshal, or the local fire authority. [7.8.2.63 NMAC - Rp, 7.8.2.62 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 8.370.14.63 B Reference NAPA 10, Standard for Portable Fire Extinguishers, 1998 Edition: 4-3 Inspection. 4-3.1* Frequency. Fire extinguishers shall be inspected when initially placed in service and after that at approximately 30-day intervals. Fire extinguishers shall be inspected at more frequent intervals when circumstances require. Based on observation and interview, the facility failed to ensure that the fire extinguishers were	A 063	A-063—The fire extinguisher located in the main dining hall was inspected and found to be in satisfactory condition. All fire extinguishers were inspected and signed off on in July, August, and September. A recurring task has been entered into TELS, our preventative maintenance tracking system to ensure that all fire extinguishers are inspected no fewer than monthly to remain compliant with NMAC 8.2.63 Type text here	11/18/24

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A 063	Continued From page 42 being maintained and inspected monthly as recommended by the manufacturer. This deficient practice could likely result in all 114 (R #s 1-114) residents identified on the census provided by the Administrator on 06/24/24, staff members, and other building occupants to be at risk of harm, injury, or death if a fire were to occur and the fire extinguishers did not work. The findings are: A. On 06/24/24 at 9:54 am, during observation of the facility, the fire extinguisher located in the main dining room hall was missing dates and signatures for May and June 2024. It had not been inspected (monthly) in compliance with the manufacturer's recommended practice. B. On 06/26/24 at 10:45 am, during an interview with the Maintenance Supervisor, he confirmed that the fire extinguisher in the main dining hall was missing dates and signatures for May and June 2024, and had not been inspected monthly according to the manufacturer's recommendation.	A 063		
A 069	7 NMAC 8.2.69 Memory Care Units MEMORY CARE UNITS: An assisted living facility that provides a memory care unit to serve residents with dementia shall comply with the provisions of subsection A-J below in addition to the rules applicable to all assisted living facilities, 7.8.2 NMAC. A. Additional definitions: The following definitions, 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	A 069	A-069—A locking device was installed on the window in room MC25 to prevent it from being opened all the way. The Memory Care Director and or the Executive Director will conduct routine inspections of all windows in MC rooms to ensure that they restrict access to the public way and to comply with NMAC 8.2.69	11/18/24

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A 069	Continued From page 43 fatal. (2) " Care coordination agreement requirement " means a written document that outlines the care and services that are provided by other outside agencies for assisted living residents that require additional care and services. (3) " Dementia " means loss of memory and other mental abilities severe enough to interfere with daily life. It is caused by changes in the brain. (4) " Memory care unit " means an assisted living facility or part of or an assisted living facility that provides added security, enhanced programming and staffing appropriate for residents with a diagnosis of dementia, Alzheimer ' s disease or other related disorders causing memory impairments and for residents whose functional needs require a specialized program. (5) " Secured environment " means locked (secured/monitored) doors/fences that restrict access to the public way for residents who require a secure unit. B. Care coordination requirement. An assisted living facility that accepts residents with memory issues shall determine which additional services and care requirements are relevant to the resident and disease process. (1) The medical diagnosis and ISP shall be utilized in the determination of the need for additional services. (2) The assisted living facility shall ensure the coordination of services and shall have evidence of an agreement of care coordination for all 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	A 069		

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A 069	Continued From page 44 residents shall have a minimum of twelve (12) hours of training per year related to dementia, Alzheimer ' s disease, or other pertinent information. D. Individual service plan (ISP). An assisted living facility that admits memory care unit residents shall create an ISP in coordination with the resident ' s primary care practitioner, in compliance with the requirements outlined in " Individual Service Plan, " 7.8.2.26 NMAC, pursuant to a team meeting as described in " Exceptions to admission, readmission and retention, " Subsection C of 7.8.2.20 NMAC, and which ensures the following criteria: (1) identification of the resident's needs specific to the memory care unit and the services that are provided; each memory unit resident shall receive the services necessary to meet the individual resident ' s needs; (2) medications shall be self-administered, self-administered with assistance by an individual that has completed a state approved program in medication assistance or administered by the following individuals: (a) a physician; (b) a physician extender (PA or NP); (c) a licensed nurse (RN or LPN); (d) the resident if their PCP has approved it; (e) family or family designee; and (f) any other individual in accordance with applicable state and local laws. E. Assessments and reevaluations. (1) An assessment shall be completed by a 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 069	Type text here	

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A 069	Continued From page 45 (a) The resident shall have a medical evaluation and documentation by a physician, physician's assistant or a nurse practitioner within six (6) months of admission. (b) The pre-admission assessment shall include written findings, an evaluation of less restrictive alternatives and the basis for the admission to the secured environment. The written documentation shall include a diagnosis from the resident's PCP of Alzheimer's disease or other dementia and the need for the resident to reside in a memory care unit. (c) Only those residents who require a secured environment placement or whose needs can be met by the facility, as determined by the assessment prior to admission or on review of the individual service plan (ISP), shall be admitted. (2) A re-evaluation must be completed every six (6) months and when there is a significant change in the medical or physical condition of the resident that warrants intervention or different care needs, or when the resident becomes a danger to self or others, to determine whether the resident ' s stay in the assisted living facility memory care unit is still appropriate. F. Documentation in the resident ' s record. In addition to the required documentation pursuant to 7.8.2.21 NMAC, the following information shall be documented in the resident ' s record: (1) the physician ' s diagnosis for admission to a secure environment or a memory care unit; (2) the pre-admission assessment; and (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	A 069		

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A 069	Continued From page 46 the public way. These include but are not limited to: (a) double alarm systems; (b) gates connected to the fire alarm; and (c) tab alarms for residents at risk for elopement. (2) In addition to the interior common areas required by this rule, the facility shall provide a safe and secure outdoor area for the year round use by the residents. (a) Fencing or other enclosures shall prevent elopement and protect the safety and security of the residents. (b) Residents shall be able to independently access the outdoor areas. (3) Locked areas shall have an access code or key which facility employees shall have available on their person or on the locking unit itself at all times. H. Resident rights. In addition to the requirements pursuant to 7.8.2.32 NMAC, the following shall apply: (1) the resident's rights may be limited as required by their condition and as identified in the ISP; (2) the resident who believes that he or she has been inappropriately admitted to the secured environment may request the facility in contact the resident ' s legal guardian, or an advocate such as the ombudsman or the primary care practitioner; upon request, the facility shall assist the resident in making such contact. I. Disclosure to residents. A facility that operates a secured environment shall disclose to the 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	A 069		

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A 069	Continued From page 47 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: 8.370.14.69 G (1) Based on observations and interviews, the facility failed to ensure windows in the Memory Care Unit (MCU) were secure and restricted access to the public way (a passageway or roadway). This deficient practice could likely result in the 27 (R #s 1-27) MCU residents being at risk of harm or injury if they elope (unauthorized departure from the facility) through an open window. The findings are: A. On 06/27/24 at 6:45 am, during an observation of the MCU exterior of the building, the following was observed: 1. One of the windows to a resident room that faces the east side of the building parking lot and nearby road was open approximately 2 feet (ft). 2. Upon entrance into the MCU, the window was found to be in room #25, on the left side of the room. The window did not to contain a blocking device (a piece of metal on both sides of	A 069		

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A 069	Continued From page 48 the window frame) to prevent it from opening all the way, as was found on the other windows of the MCU. B. On 06/27/24 at 8:23 am, during an interview, the Registered Nurse (RN) Director of Health Services confirmed that the window in room #25 on the far left side of the room did not have a blocking device installed on the window like the other windows in the other bedrooms in the MCU, which only allow windows to open about 6-inches (in). She stated she was concerned about all MCU residents because they could enter the room and attempt to elope from the window since it opens approximately 2 ft. She confirmed that this could compromise the secure environment of the MCU. C. On 06/27/24 at 9:27 am, during an observation of the interior of room #25, the window to the far right did not contain a blocking device, allowing it to open approximately 2 feet. D. On 07/08/24 at 11:13 am, during a follow-up interview with the RN Director of Health Services, she confirmed that the window to the far right of room #25 did not contain a blocking device, allowing it to open approximately 2 feet.	A 069		