PRINTED: 02/03/2025
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Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	5772	A. BUILDING: _____ B. WING _____	C 01/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARISTOCRAT OPERATING COMPANY II, LLC	1111 E MOUNTAIN AVENUE LAS CRUCES, NM 88001

(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 that was completed on 01/22/25 for the state requirements of NMAC 8.370.14, Regulations for Assisted Living Facilities for Adults. Resident Census: 38 Complaint Intake NM [redacted] was investigated and deficiencies were not cited. Complaint Intake NM [redacted] was investigated and deficiencies were not cited. Complaint Intake NM [redacted] was investigated and deficiencies were not cited.	8 000		
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:	8 032		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: Director | (X6) DATE: 2/4/2025

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8 032	Continued From page 1 (1) a narrative description of the incident; (2) the result of the facility's investigation shall be recorded on the state approved incident report form for the current year, pursuant to 8.370.9 NMAC; and (3) plans for further actions in response to the incident. [8.370.14.32 NMAC - N, 7/1/2024] This REQUIREMENT is not met as evidenced by: 8.370.14.32 A (1) and 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. B. The facility is responsible for conducting and documenting the investigation of all incidents within five (5) business days and shall submit a copy of the investigation report to the licensing authority. A copy of the report and the documentation, including the date and time that it was submitted to the licensing authority, shall be maintained on file at the facility. Based on record review and interview, the facility failed to ensure for 2 (R #2 and R #3) of 2 (R #2	8 032		

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8 032	Continued From page 2 and R #3) residents that the facility report incidents of suspected abuse that had or could threaten the health, safety, or welfare of the residents and staff to the Licensing Authority (LA) within twenty-four (24) hours and conduct an internal investigation and submitted an investigation follow-up report to the LA within five (5) business days from when an incident occurred. These deficient practices could likely result in the 38 (R #s 1-38) residents listed on the resident census provided by the facility's Director on 01/21/25 to be at risk of harm, injury, or death if an unusual occurrence, suspected abuse or neglect is not investigated and reported to the Licensing Authority. The findings are: A. Record review of Nurse #1's file revealed: 1. On 02/05/24, Nurse #1 was verbally abusive to R #2 and R #3. 2. On 02/12/24, following an investigation performed by the facility's Director, Nurse #1 was terminated from employment due to a violation of resident rights for emotional/verbal abuse. B. Record review of the facility's incident report dated 02/05/24, revealed the incident was not reported to the LA. C. On 01/22/25 at 10:21 AM, during an interview, the facility's Director confirmed the incident of Nurse #1's emotional/verbal abuse to R #2 and R #3 was not reported to the LA.	8 032	Responds to deficiency 8.370.14.32(A) (1) (B) (2/3/25) In Service was implemented with lead employee including managment (Director & Nurse). On Incident reporting and 5 day follow-up. An incident report and/or 5 day follow up has been implemented with Director & Nurse, to make sure that no incident report or follow up to the Licensing Authority is missed. (2-5-25) Facility has implemented a Calander for incident reporting including follow-ups in the Nurses office for monitoring all reports.	
8 033	8 NMAC 370.14.33 Resident Rights	8 033		

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8 033	Continued From page 3 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. 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	8 033		

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8 033	Continued From page 4 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 unreasonable restriction; (e) are given a 15 calendar day, written notice before room transfers or discharge from the facility unless there is immediate danger to self or others in the facility; (f) have an environment that fosters social interaction and avoids social isolation; (g) or their surrogate decision makers, are informed of and consent to the services provided by the facility; (h) have the right to voice grievances to the	8 033		

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8 033	Continued From page 5 facility staff, public officials, the ombudsmen, any state agency, or any other person, without fear of reprisal or retaliation; (i) have the right to have their complaints addressed within 14 calendar days or sooner; (j) have the right to participate in the development of their care plan/ISP; (k) have the right to choose a doctor, pharmacist and other health care provider(s); (l) have the right to participate in medical treatment decisions and formulate advance directives such as living wills and powers of attorney; (m)have the right to keep and use personal possessions without loss or damage; (n) have the right to manage and control their personal finances; (o) have the right to freely organize and participate in a resident association that may recommend changes in the facility's policies, services and management; (p) shall not be required to work for the facility; and (q) are protected from unjustified room transfers or discharge. E. The resident's rights shall not be restricted unless this restriction is for the health and safety of the resident, agreed to by the resident or the resident's surrogate decision maker and outlined in the resident's individual service plan. [8.370.14.33 NMAC - N, 7/1/2024] This REQUIREMENT is not met as evidenced by: 8.370.14.33.D (1), (11a) Based on record review, interview, and observation the facility failed to ensure for 2 (R #2 and R #3) of 2 (R #2 and R #3) residents were treated with courtesy, respect, dignity and	8 033		

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8 033	Continued From page 6 compassion and were free from emotional abuse. This deficient practice could likely place residents at risk for developing long-term mental health damage and could contribute to the decline of their physical health. The findings are: A. Record review of Nurse #1's employee file revealed an undated letter of employment separation for Nurse #1 and signed by the facility Director that indicated the following: 1. Nurse #1's employment was terminated effective 02/12/24. 2. Nurse #1 was involved in a verbal confrontation on 02/05/24 with two residents. 3. Nurse #1 was heard yelling and threatening the residents on 02/05/24. 4. Nurse #1 violated the two residents' rights. B. Record review of R #3's witness statement dated 02/06/24 revealed the following: 1. On 02/05/24, Nurse #1 approached R #3 about dirtying the bathroom with feces. 2. R #3 denied tha[redacted]had gotten feces outside of the toilet in the bathroom. 3. Nurse #1 called R #3 a[redacted] and threatened to "kick" R #3 out of the facility. 4. R #2 stood up for R #3 when Nurse #1 began to yell at and threaten R #3. Nurse #1 told R #2 to "shut up" and that[redacted] 5. Nurse #1 told R #2 and R #3 he was going to call the cops to get R #2 and R #3 out of the facility. C. Record review of R #2's witness statement dated 02/06/24 revealed the following: 1. On 02/05/24, Nurse #1 entered R #2 and	8 033	Responds to deficiency 8NMAC 370.14.33 Residents Rights On 2/5/2024 the nurse was immediatly removed from the premisses, until investigation was completed on 2/12/2024. On 2/5/2024 both residents were reassusered that the nurse was out of the facility and will no longer be permitted to faicility until investation was completed. On 2/12/2024 Director spoke with both residents to ensure them that the nurse would no longer be returning to the facility and that they would be safe.	

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8 033	Continued From page 7 R #3's room and yelled at R #3 stated R #3 dirtied (gotten feces outside of the toilet) the bathroom with bowel. 2. R #3 denied [redacted] dirtied the bathroom and Nurse #1 called R #3 "dirty". 3. Nurse #1 threatened to separate R #2 and R #3 and not allow them to continue to live in the same bedroom. 4. Nurse #1 told R #2 and R #3 that they were "done" and they "were out of here." D. Record review of Activities Director's typed witness statement dated 02/05/24 revealed the following: 1. On 02/05/24 at 1:25 pm, she overheard Nurse #1 and a resident (R #2) yelling at each other from down the hall. 2. She heard Nurse #1 tell a resident (R #2) to "shut up" multiple times. 3. She went to where the yelling was and Nurse #1 and R #2 were yelling at each other. R #3 was not yelling. 4. She stated she could still hear Nurse #1 and R #2 yelling as she left the area to notify the facility's Director. 5. She encouraged R #2 and R #3 to go to their shared room to calm down and to avoid Nurse #1 upon returning to R #2 and R #3 room. 6. R #2 and R #3 returned to their room. 7. Nurse #1 followed R #2 and R #3 back to their room and Nurse #1 began yelling at and threatening R #3 by saying [redacted] Nurse #1 told both R #2 and R #3 "I am done with both of you and you are out of here". 8. On 02/05/24, R #2 was "mad, scared, maybe even depressed" and having anxiety due to Nurse #1 telling R #2 that he (Nurse #1) was going to ge[redacted] (R #2) out of the facility. 9. On 02/05/24, R #2 avoided any further interaction with Nurse #1.	8 033		

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8 033	Continued From page 8 10. On 02/05/24, R #2 stayed [redacted] room more often than was usual. 11. On 02/05/24, R #2 was relieved once Nurse #1 was no longer at the facility. E. Record review of Direct Care Staff (DCS) #3's written witness statement dated 02/05/24 revealed the following: 1. Nurse #1 raised his voice at one of the residents (R #2). 2. Nurse #1 was telling the resident (R #2) repeatedly to "shut up" and "to get out of my face." F. Record review of Nurse #1's emailed statement to the Director dated 02/07/24 revealed the following: 1. On 02/05/24, he went to R #3's room to speak to R #3 about feces left outside of the toilet in the bathroom. R #2 started yelling [redacted] (Nurse #1). Nurse #1 attempted "redirection several times but without success". 2. Nurse #1 raised his voice to R #3 so that Nurse #1 could be heard over R #2 who continued "screaming." 3. Nurse #1 told R #3 "they could be separated into individual rooms because of not adhering to behavior modification agreement." 4. R #3 threatened Nurse #1 by stating "I will kick your ass." 5. Nurse #1 told R #3 that threats of bodily harm could result in law enforcement intervention. G. On 01/21/25 at 10:37 am during an interview, R #2 stated the following: 1. On 02/05/24, Nurse #1 called R #2 and R #3 [redacted] and [redacted] 2. Nurse #1 told R #2 and R #3 that he (Nurse #1) was going to "split" them up, [redacted], because R #3 "didn't deserve	8 033		

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8 033	Continued From page 9 [redacted] referring to R #2. 3. Nurse #1 was "very rude and mean," and was threatening "to put us out, out on the street." 4 [redacted] felt scared and angry following the interaction with Nurse #1. 5. Nurse #1's actions made R #3 cry which made R #2 upset. H. On 01/22/25 at 10:20 am during an interview, the facility's Director stated the following: 1. She investigated the allegations against Nurse #1 and found sufficient evidence to substantiate a violation of resident rights. 2. R #2 and R #3 seemed nervous and uncomfortable when Nurse #1 was on facility premises to pick up his paycheck prior to being discharged from employment. 3. R #2 and R #3 exhibited their normal behaviors when they learned that Nurse #1 was discharged from employment. I. On 01/22/25 at 11:00 am during an interview, R #3 stated the following: 1. On 02/05/24, Nurse #1 called R #3 "a liar" about having completed a shower stating "you smell like shit," "I'll fight you right now, and I'll kick your ass." 2. Nurse #1 threatened R #2 and R #3 with being "kicked out" of the facility. [redacted] felt scared following the interaction with Nurse #1. J. On 01/22/25 at 1:21 pm during an interview, the Activities Director stated the following: 1. On 02/05/24, she overheard R #2 and Nurse #1 yelling at each other. 2. She observed Nurse #1 following R #2 and R #3 into their room. 3. She separated R #2, R #3 and Nurse #1, but Nurse #1 re-entered R #2's and R #3's room	8 033		

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8 033	Continued From page 10 without permission, yelling at the top of his lungs saying "they're outta here!" 4. R #2 was observed to be quieter and more withdrawn following the incident with Nurse #1. R #2 was typically talkative.	8 033		
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 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	8 035		

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8 035	Continued From page 11 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 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	8 035		

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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
8 035	Continued From page 12 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. 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.	8 035		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	5772	A. BUILDING: _____ B. WING _____	C 01/22/2025

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8 035	Continued From page 13 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 Based on record review and interview, the facility failed to ensure for 1 (R #1) of 1 (R #1) resident that the medications including over-the-counter medications and PRN (as needed) medications, were administered with an order from the physician, physician assistant or nurse practitioner and with entry into the resident's medication record. This deficient practice could likely result in the 38	8 035		

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8 035	Continued From page 14 (R #s 1-38) of 38 residents to be at risk of harm, adverse reaction, or death if the medication administered is not authorized by the resident's physician and the medication is not recorded in the medication record. The findings are: A. Review of Complaint Intake [redacted] revealed Direct Care Staff (DCS) #1 reported: 1. An Licensed Practical Nurse (LPN) prescribed a medication to give to the resident for nausea that belonged to someone else. 2. The resident was administered [redacted] B. Record review of R #1's Medication Administration Record (MAR) dated 12/2023 revealed the MAR did not contain a PRN [redacted] medications listed. C. Record review of R #1's resident file revealed the file did not contain a Physician's Orders for [redacted] D. On 01/21/25 at 4:21 PM, during an interview the Director confirmed: 1. The facility has a "house stock" of over-the-counter medications that she buys for both residents and staff to use as needed. 2. There is no physicians orders for the "house stock" over-the-counter medications that she buys. 3. The "house stock" over-the-counter medications are not listed on the Residents MARs. 4. Administration of "house stock" over-the-counter medications are not recorded on the MAR. 5. There is no documentation of	8 035	Responds to deficiency 8 NMAC 370.14.35 Medication A communication on 1/22/2025 between the Physician, Director and Nurse has been implemented on 1/24/2025 of getting physicain orders for any over the counter medication for any resident that requires OT frequently.	

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8 035	Continued From page 15 administration of the "house stock" over-the-counter medications. 6. When a resident is complaining of an issue, such as a stomachache, they call the house nurse and report what issue a resident is having and the house nurse will tell the staff what "house stock" over-the-counter medication to administer as well as the dosage.	8 035	1/22/2025 Any over the counter medication is on the MAR and all have labeled by the pharmacy.	