STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	7020	A. BUILDING: _____ B. WING _____	C 08/09/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARLER MANOR	3712 GENERAL PATCH ST NE ALBUQUERQUE, NM 87111

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 000	Initial Comments The following deficiencies were cited during a Complaint survey completed on 08/09/21 for the state requirements of 7 NMAC 8.2, Regulations for Assisted Living Facilities, Complaint Intake # NM53286 was substantiated with deficiencies cited.	A 000	Initial Comments The providers compliant answers to complaint survey is provided on pages following the Assisted Living Facilities regulation documented in the first column In answer to complaint intake #NM53286	
A 020	7 NMAC 8.2.20 Admissions and Discharge ADMISSIONS AND DISCHARGE: The facility shall complete an admission agreement for each resident. The administrator of the facility or a designee responsible for admission decisions shall meet with the resident or the resident ' s surrogate decision maker prior to admission. No resident shall be admitted who is below the age of eighteen (18) or for whom the facility is unable to provide appropriate care. A. Admission agreement. The admission agreement shall include the following information: (1) the parties to the agreement; (2) the program narrative; (3) the facility's rules; (4) the cost of services and the method of payment; (5) the refund provision in case of death, transfer, voluntary or involuntary discharge; (6) information to formulate advance directives; (7) a written description of the legal rights of the residents translated into another language, if necessary; (8) the facility's staffing ratio; (9) written authorization for staff to assist with medications; (10) notification of rights and responsibilities pursuant to the Incident Reporting Intake, *Processing and Training Requirements*, 7.1.13 NMAC;	A 020	7 NMAC 8.2.20 Admissions and Discharge continue to Page 5 Continue to page 2	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	7020	A. BUILDING: _____ B. WING _____	C 08/09/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARLER MANOR	3712 GENERAL PATCH ST NE ALBUQUERQUE, NM 87111

(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 020	Continued From page 1 (11) the facility ' s bed hold policy; and (12) the admission agreement may be terminated if an appropriate placement is found for the resident, under the following circumstances: (a) there shall be a fifteen (15) day written notice of termination given to the resident or his or her surrogate decision maker, unless the resident requests the termination; (b) the resident has failed to pay for a stay at the facility as defined in the admission agreement; (c) the facility ceases to operate or is no longer able to provide services to the resident; (d) the resident ' s health has improved sufficiently and therefore no longer requires the services of the facility; (e) termination without prior notice is permitted in emergency situations for the following reasons: (i) the transfer or discharge is necessary for the resident's safety and welfare; (ii) the resident's needs cannot safely be met in the facility; or (iii) the safety and health of other residents and staff in the facility are endangered; (13) the facility shall provide a thirty (30) day written notice to residents regarding any changes in the cost or the material services provided; a new or amended admission agreement must be executed whenever services, costs or other material terms are changed; and (14) facilities representing their services as " specialized " must disclose evidence of staff specialty training to prospective residents. B. Restrictions in admission. The facility shall not admit or retain individuals that require twenty-four (24) hour continuous nursing care, refer to Subsection U of 7.8.2.7 NMAC Definitions. This rule does not apply to hospice residents who have elected to receive the hospice benefit. *Conditions or circumstances that usually require*	A 020	Continue from page 1 Continue to page 3	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	7020	A. BUILDING: _____ B. WING _____	C 08/09/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARLER MANOR	3712 GENERAL PATCH ST NE ALBUQUERQUE, NM 87111

(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 020	Continued From page 2	A 020	Continued from page 2	

continuous nursing care may include but are not limited to the following:
(1) ventilator dependency;
(2) pressure sores and decubitus ulcers (stage III or IV);
(3) intravenous therapy or injections;
(4) any condition requiring either physical or chemical restraints;
(5) nasogastric tubes;
(6) tracheostomy care;
(7) residents that present an imminent physical threat or danger to self or others;
(8) residents whose psychological or physical condition has declined and placement in the current facility is no longer appropriate as determined by the PCP;
(9) residents with a diagnosis that requires isolation techniques;
(10) residents that require the use of a Hoyer lift; and
(11) ostomy (unless resident is able to provide self care).
C. Exceptions to admission, readmission and retention. If a resident requires a greater degree of care than the facility would normally provide or is permitted to provide and the resident wishes to be re-admitted or remain in the facility and the facility wishes to re-admit or retain the resident. The facility shall comply with the following requirements.
(1) Convene a team, comprised of:
(a) the facility administrator and a facility health care professional if desired;
(b) the resident or resident ' s surrogate decision maker; and
(c) the hospice or home health clinician.
(2) The team shall jointly determine if the resident should be admitted, readmitted or allowed to remain in the facility. Team approval shall be in

Continue to page 4

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	7020	A. BUILDING: _____ B. WING _____	C 08/09/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARLER MANOR	3712 GENERAL PATCH ST NE ALBUQUERQUE, NM 87111

(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 020	Continued From page 3 writing, signed and dated by all team members and the approval shall be maintained in the resident's record and shall: (a) be based upon an individual service plan (ISP) which identifies the resident's specific needs and addresses the manner that such needs will be met; (b) ensure that if the facility is licensed for more than eight (8) residents and does not have complete fire sprinkler coverage, the facility shall maintain an evacuation rating score of prompt as determined by the fire safety equivalency system (FSES); (c) evaluate and outline how meeting the specific needs of the resident will impact the staff and the other residents; and (d) include an independent advocate such as a certified ombudsman if requested by the resident, the family or the facility. (3) The team recommendation shall be maintained on site in the resident ' s file. (4) When a resident is discharged, the facility shall record where the resident was discharged to and what medications were released with the resident. D. Coordination of care. (1) Assisted living facilities shall have evidence of care coordination on an ISP for all services that are provided in the facility by an outside health care provider, such as hospice or home health providers. (2) Residents shall be given a list of providers, including hospice and home health if applicable, and have the right to choose their provider. If applicable, the referring party shall disclose any ownership interest in a recommended or listed provider. [7.8.2.20 NMAC - Rp, 7.8.2.19 NMAC & 7.8.2.20 NMAC, 01/15/2010]	A 020	Continued from page 3 Continue to page 5	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	7020	A. BUILDING: _____ B. WING _____	C 08/09/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARLER MANOR	3712 GENERAL PATCH ST NE ALBUQUERQUE, NM 87111

(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 020	Continued From page 4 This REQUIREMENT is not met as evidenced by: 7.8.2.20 B (2 & 5) Based on record review and interview the facility failed to ensure for 1 (R #1) of 1 (R #1) former resident [redacted] that they did not admit residents: 1. Identified as needing and higher level of care than the facility is allowed to provide. 2. Who required continuous nursing care (care that only Licensed Nurses or Medical Professional are allowed to provide) such as: [redacted] This deficient practice could likely result in the former and current residents being at risk of harm, illness, and/or death if: 1. The facility is admitting residents who require a higher level of care than the staff is able/allowed to provide. 2. Non-licensed/qualified staff: a. Are administering liquids and medications incorrectly causing the tube to clog, leak fluids, or the tube become dislodged and infections occur. b. Improperly changing and cleaning the urostomy bag and germs/bacteria causes infections to occur.	A 020	Continued from page 4 as stated following regulation for Assisted Living 7 NMAC 7.8.2.20 B (2 & 5) B (2)Pressure sores and decubitus ulcers (stage III or IV) The facility acted to ensure compliance Individual (R#1) had [redacted] 2020 page 1 as healed B (5) Nasogastric tubes Requirement evidenced answered 1 & 2 a&b The individual R#1 had an on call geriatric doctor that recommended a home health agency with the RN to provide medical services in house for the needs of R#1 as well as OT,PT and Speech therapy along with the doctors services. The facility co-owner was trained in the proper procedures in caring for and or feeding via the peg tube for his family member by a doctor at one of California's universities. Peg tubes or feeding tubes are not stated in the regulation as requiring continuous nursing care. Corrective Action In the future the facility will not admit individuals with higher levels of care needs as these. The administrator will complete the evaluation and then someone from the medical care team will review the evaluation and sign off as approved before admission Quality retention assessments will be performed every six months by administrator to ensure compliance The on call geriatric doctor stated in her assessment notes dated 12/4/21 page 1, that the urostomy bag was to be changed out monthly by interventional radiology At no time was the staff at the facility expected to change out the urostomy bag. Deficient Practice Narrative page 6 Continue to page 6	12/3/2020 4/7/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	7020	A. BUILDING: _____ B. WING _____	C 08/09/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARLER MANOR	3712 GENERAL PATCH ST NE ALBUQUERQUE, NM 87111

(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 020	Continued From page 5 The findings are: A. Record review of a Duty (resident care needed) List dated 12/07/20, revealed that R #1 needed care and assistance with the following: [redacted] B. Record review of R #1's December, 2020 Medication Administration Record (MAR) revealed that the resident's medications needed to be crushed and given through the [redacted] C. Record review of R #1's Home Health Certification (period 12/01/20 through 01/29/21) and Plan of Care signed by physician on 12/14/20, revealed R #1 had the following conditions that are not generally allowed in Assisted Living Facilities: [redacted] D. On 08/05/21 at 2:15 pm, during at interview with the Home Health (HH) Nurse, she stated that R #1 was not at the facility very long. R #1 required a heavy/high level of care. HH nurse observed R #1 was in a [redacted] and did appear to be declining. She provided [redacted] and stated that the [redacted] needed to be flushed daily and that she only visited R #1 twice a week. R #1's [redacted] was supposed to be [redacted] on the days [redacted] did not visit. The HH nurse stated that if the [redacted]	A 020	Continued from page 5 Deficient practice narrative 1 & 2 a&b These statements imply that they could be happening and are unfounded and have no relevance To ensure compliance with the Division of Health Improvement The Facility owners have not participated in deficient practices that could result in any resident being at risk of harm, illness or death. 1.We do not admit residents that need continuous 24 hour skilled medical staff. 2. a.We have never administered liquids or medications incorrectly, or clogged any tubes causing leaks or caused tubes to be dislodged so infections would occur in any aparatus. b.We have never changed or cleaned a urostomy bag. Findings Narrative Comments A. Duty not found in file with date 12/7/2020 for R#1 C. 1. Regulation only specifies stage III and IV pressure ulcers (this item already referenced on page 5 B2) The pressure ulcer in question was almost healed over before arriving to facility as referenced in doctors notes 2. Regulation states nasogastric tubes (already referenced page 5, 1 & 2 a&b) 3. Foley is not stated in the state regulation Foley is always inserted by medical staff The facility staff are to only empty bag and contact nurse or doctor if any residents are in need of assistance Continue to page 7	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	7020	A. BUILDING: _____ B. WING _____	C 08/09/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARLER MANOR	3712 GENERAL PATCH ST NE ALBUQUERQUE, NM 87111

(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 020	Continued From page 6 was not [redacted] everyday there would be a risk of the [redacted] which fortunately did not happen. HH nurse stated that she had known and provided care for R #1 when [redacted] was in independent living, before [redacted] had the [redacted] and at that time R #1 was able to do [redacted] care by [redacted]. She stated that R #1 was not receiving any wound care. HH nurse said that OT (occupational therapy) and PT (physical therapy) were coming to see R #1 at this facility and at the previous Assisted Living [redacted] was in. She said that R #1 had a big decline when she saw [redacted] for the last time when [redacted] moved into the facility and that all [redacted] visits would be documented. E. On 08/06/21 at 11:03 am, during an interview with R #1's [redacted] she stated the 1st couple of days were fine, then the lady (Administrator/owner) kinda snapped. [redacted] stated that before [redacted] moved in, the Administrator/Owner was asked if the facility could provide the extra care [redacted] needed because [redacted] According to R #1's [redacted] the Administrator/Owner said yes, that her husband (Co-Owner) could do it, because he had cared for a family member who had a [redacted] F. On 08/06/21 at 11:30 am. during an interview with R #1's [redacted] stated that on day 3 or 4 the Administrator/Owner did not put [redacted] G. On 08/08/21 at 1:06 pm, during an interview with the Administrator/Owner, she stated and confirmed that her husband only had a past history of how to take care of R #1's [redacted] *because he had cared for a family member who* had one in the past. She confirmed that neither of	A 020	Continued from page 6 E. Narrative Comment R#1's son dumped a foley bag of approximately *1000 cc of urine on the wood floor* and was trying to wipe it up with paper chucks. We needed him out of the room fast. Comment is a duplicate - answer is on page 5 1 &2 a&b and corrective action applies F. Narrative comment Urostomy bag was not a factor in this case. Duplicate answer is found above for Narrative E. G. Narrative comment Duplicated answer is on page 5 (1&2 a&b) Continue to page 8	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	7020	A. BUILDING: _____ B. WING _____	C 08/09/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARLER MANOR	3712 GENERAL PATCH ST NE ALBUQUERQUE, NM 87111

(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 020	Continued From page 7 she or her husband were experience or trained on how to care for the urostomy. During the interview and a review of the regulations regarding admitting residents that required a higher level of care than the Assisted Living Facilities are allowed to provide and the exemption process, the Administrator /owner confirmed she was not aware of and did not follow the regulations regarding admitting residents who require a higher level of care.	A 020	Continued from page 7	
A 025	7 NMAC 8.2.25 Resident Evaluation RESIDENT EVALUATION: A. A resident evaluation shall be completed by an appropriate staff member within fifteen (15) days prior to admission to determine the level of assistance that is needed and if the level of services required by the resident can be met by the facility. B. The initial resident evaluation shall establish a baseline in the resident ' s functional status and thereafter assist with identifying resident changes. The resident evaluation shall be reviewed and updated at a minimum of every six (6) months or when there is a significant change in the resident ' s health status. C. The resident ' s evaluation shall be documented on a resident evaluation form and at a minimum include the following abilities, behaviors or status: (1) activities of daily living; (2) cognitive abilities; reasoning and perception; the ability to articulate thoughts, memory function or impairment, etc; (3) communication and hearing; ability to communicate needs and understand instructions, etc; (4) vision;	A 025	Continue to page 9	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	7020	A. BUILDING: _____ B. WING _____	C 08/09/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARLER MANOR	3712 GENERAL PATCH ST NE ALBUQUERQUE, NM 87111

(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 025	Continued From page 8 (5) physical functioning and skeletal problems; (6) incontinence of bowel/bladder; (7) psychosocial well-being; (8) mood and behavior; (9) activity interests; (10) diagnoses; (11) health conditions; (12) nutritional status; (13) oral or dental status; (14) skin conditions; (15) medication use and level of assistance needed with medications; (16) special treatments and procedures or special medical needs such as hospice; and (17) safety needs/high risk behaviors; history of falls agitation, wandering, fire safety issues, etc. D. The resident evaluation shall include a history and physical examination and an evaluation report by a physician or a physician extender within six (6) months of admission. A resident shall have a medical evaluation by a physician or a physician extender at least annually. E. The resident evaluation shall be reviewed and if needed revised by a licensed practical nurse, registered nurse or physician extender at the time the individual service plan is reviewed, at a minimum of every six (6) months or when a significant change in health status occurs. [7.8.2.25 NMAC - Rp, 7.8.2.25 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.25 A C (11) E Based on record review and interview, the facility	A 025	Continued from page 8 Requirement evidenced answered 7.8.2.25 A C (11) E Continued to page 10	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	7020	A. BUILDING: _____ B. WING _____	C 08/09/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARLER MANOR	3712 GENERAL PATCH ST NE ALBUQUERQUE, NM 87111

(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 025	Continued From page 9 failed to ensure that resident initial assessments/evaluations: 1. Were completed within 15-days prior to admission. 2. Addressed all resident health conditions. 3. Were signed by a Licensed Nurse (LN), Registered Nurse (RN), or Physician Extender (PE). This deficient practice could likely to result in the 6 (R #s 1-6) former/current residents listed on the resident census provided by the Administrator/Owner on 08/03/21, not receiving appropriate care/services upon admission and stay at the facility if the Direct Care Staff (DCS) are not aware of what the resident's needs and conditions are upon admission. and reviewed and signed by the facility nurse.. The findings are: Findings related to initial Evaluations/Assessments: A. Record review of R #3's evaluation/assessment date[redacted]21, revealed that the evaluation was not completed within 15-days prior to admission on [redacted]21. B. Record review of R #4's evaluation/assessment dated 06/15/21, revealed that the evaluation was not completed within 15-days prior to admission on [redacted]21. C. On 08/03/21 at 2:30 pm, during an interview with the Administrator/Owner she confirmed that R #s 3 and 4's evaluations were not completed within 15-days prior to admission.	A 025	Continued from page 9 Requirement evidence answered 7.8.2.25 A B C (11) E *Narrative Comment 1, 2, & 3* All Residents on or before admission have a signed assessment from their physician or RN that has been given to us for evaluation. In the future the facilities forms will be reviewed and signed on or whithin 15 days before admission by a doctor or nurse *Quality checks will be made on each admission of* resident before arrival by the administrator Deficient Practice answer These statements imply that they could happen and are unfounded and have no relevance. The administrator/ owner and co-owner are the DCS and were very aware of each Residents needs due to the doctors assessments. Findings A, B, C A. R #3 There is a signed assessment from an LPN dated 6/22/2021 in the file for the discharge that was waiting on acceptance from the facility. In the future the facilities forms will be reviewed and signed on or within 15 days before admission by a *doctor or nurse* Quality checks will be made on each admission before arrival by administrator B. R #4 There is a signed assessment from the physician dated 6/10/2021 and an acceptance assessment from the physician accepting Home health dated 6/10/2021as well. In the future the facilities forms will be reviewed and signed on or within 15 days before admission by a doctor or nurse Quality checks will be performed on each admission before arrival by administrator C. In the future the facilities forms will be reviewed and signed on or before admission by a doctor or Nurse Quality checks will be made on each admission before arrival by administrator Continue to page 11	4/7/2022 4/7/2022 4/7/2022 4/7/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	7020	A. BUILDING: _____ B. WING _____	C 08/09/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARLER MANOR	3712 GENERAL PATCH ST NE ALBUQUERQUE, NM 87111

(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 025	Continued From page 10 Finding related to resident conditions not addressed: D. Record review of former resident R #1's Evaluation/Assessment dated 12/02/20 revealed that the following conditions that the resident had were not addressed: [redacted] E. On 08/09/21 at 2:20 pm, during an interview with the Administrator, she confirmed that R #1's Evaluation/Assessment dated 12/02/20 did not address the conditions listed above. Finding related to Evaluation/Assessment not reviewed/signed by a Registered Nurse (RN) F. Record review of R #1's Evaluation/Assessment dated 12/02/20, revealed that it was not reviewed/signed by a nurse. G. On 08/09/21 at 2:20 pm, during an interview with the Administrator, she confirmed that R #1's Evaluation/Assessment dated 12/02/20, was not reviewed and/or signed by a nurse. H. Record review of R #2's	A 025	Continued from page 10 Findings to resident conditions not addressed D. (1,2,3,4) Narrative Comment Duplicate answer is found on page 5 The physicians assessments and the home health assessments did have all of R#1's conditions and were in the possession of the facility on [redacted]2020 [redacted] Corrective Action In the future the facility will ensure that every condition of residents will be documented in the admission evaluation and reviewed and signed by a doctor or nurse E. Narrative Comment The physicians assessments and the home health assessments did have all of R#1's conditions and were in the possession of the facility on 12/2/2020 In the future the facilities admission forms will be updated to include all possible resident conditions and will be reviewed and signed on or before admission by a doctor or nurse. Quality checks will be made on each admission before arrival by administrator F. Narrative comment duplicate see answer above in E Narrative comment G. Narrative Comment duplicate see answer above in E Narrative Comment Continued to page 12	4/7/2022 4/7/2022 4/7/2022 4/7/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	7020	A. BUILDING: _____ B. WING _____	C 08/09/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARLER MANOR	3712 GENERAL PATCH ST NE ALBUQUERQUE, NM 87111

(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 025	Continued From page 11 Evaluation/Assessment dated 10/12/20. not signed by RN I. On 08/09/21 at 3:34 pm, during an interview with the Administrator/Owner, she confirmed that R #2's Evaluation/Assessment was not reviewed and/or signed by the facility nurse.	A 025	Continued from page 11 Narrative comment duplicate H,I The facility received R#2 's doctors assessment dated [redacted]2020 on or before the date of admission. In the future the facilities admission forms will be updated to include all possible resident conditions and will be reviewed and signed on or before admission by a doctor or nurse. Quality checks will be made on each admission before arrival by administrator	4/7/2022
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		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	7020	A. BUILDING: _____ B. WING _____	C 08/09/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARLER MANOR	3712 GENERAL PATCH ST NE ALBUQUERQUE, NM 87111

(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 033	Continued From page 12 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	Continued from page 12 Continued to page 14	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	7020	A. BUILDING: _____ B. WING _____	C 08/09/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARLER MANOR	3712 GENERAL PATCH ST NE ALBUQUERQUE, NM 87111

(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 033	Continued From page 13	A 033	Continued from page 13	

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*

Continue to page 15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	7020	A. BUILDING: _____ B. WING _____	C 08/09/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARLER MANOR	3712 GENERAL PATCH ST NE ALBUQUERQUE, NM 87111

(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 033	Continued From page 14 of the resident, agreed to by the resident or the resident ' s surrogate decision maker and outlined in the resident ' s individual service plan. [7.8.2.33 NMAC - Rp, 7.8.2.34 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.33 D (4) Based on record review, observation, and interview the facility failed to ensure that the Direct Care Staff (DCS) were following the current infection control guidance to prevent the spread of the Covid-19 (a contagious disease caused by severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) by: 1. Being Screened (completing the Covid-19 questions and having their temperatures taken upon entering the facility. 2. Wearing PPE (Personal Protective Equipment (gowns, N95 face masks, goggles/faceshields and gloves)), as required based on facility and county positivity rate. This deficient practice did likely result in the 3 (R #s 1, 2, & 6) former residents (deceased) and could likely result in the 3 (R #s 3-5) current residents listed on the resident census provided by the Administrator/Owner on 08/03/21, to be at risk illness or death by the contracting the Covid-19 virus, because the DCS were not following the current infection control guidance. The findings are. A. On 08/03/21 at 10:25 am, upon entry to the facility, the Administrator/Owner was observed not wearing a mask or any type of Personal	A 033	Continued from page 14 Requirement 7.8.2.33 D (4) (4) Provide residents with a safe and sanitary environment. Requirement evidenced answered The facility was screening with covid 19 questions and taking temperatures. But did not record and keep documents as proof In the future the facility will be in compliance by storing documents with sign in paperwork. Masks, gloves, thermometer and hand sanitizer have been available at the front door Deficient Practice Narrative This statement implies that it did likely result in the 3 deaths (R#1,2,&6). R#1 did not result in death at our facility. R#1's own family brought covid and took R#1 out of our care. (no implications apply here.) This statement also implies that it could likely result in R#'s 3-5 to be at risk in illness or death which is unfounded and does not apply. Continue to page 16	7/2020 8/3/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	7020	A. BUILDING: _____ B. WING _____	C 08/09/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARLER MANOR	3712 GENERAL PATCH ST NE ALBUQUERQUE, NM 87111

(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 033	Continued From page 15 Protective Equipment (PPE). B. On 08/03/21 at 10:50 am, during an interview with the Administrator/Owner, she confirmed that the facility was not conducting (currently or in the fall/winter of 2020) routine/surveillance testing of residents or staff, because no one had Covid. C. On 08/03/21 at 11:35 am, during an interview with the Administrator/Owner, she stated and confirmed the following: 1. R #1 was not tested for Covid prior to admission [redacted]20, because [redacted]had already had covid while in the hospital/rehabilitation. 2. The facility was not reporting positive covid staff/residents to the state and continued to not report. As of this survey the facility is still not reporting. 3. R #1's [redacted] moved resident into the facility on [redacted]20 and were allowed to visit during [redacted] stay at the facility. 4. R #1's [redacted] called on 12/04/20 and told the Administrator/Owner that [redacted] was not feeling well. 5. R #1's [redacted] was tested on [redacted]20 and was positive for Covid. 6. R #1's [redacted] came into the home to visit on [redacted]20, R #1's Physician and the Home Health (HH) nurse were also visiting resident and noticed the [redacted] appeared to have symptoms of Covid-19 and informed the [redacted] that [redacted] needed to wait by the door [redacted] 7. [redacted] received positive test results on 12/11/20. 8. R #1's [redacted] had a rapid test and was negative. 9. In Dec 2020 there were 3 residents living at the facility and the only staff at the time were Owners (Administrator and husband).	A 033	Continued from page 15 Narrative comment A. It has always been the practice of the Administrator/ co-owner to wear a mask when answering the door. PPE were not required at the time of this survey as there were no suspected out breaks and all residents had covid vaccinations B. Each Resident has had their current covid shots prior to admission. It was explained by pharmacists and medical staff that anyone who just had covid would not be a threat to anyone and they should not get a vaccination for 6 months C. 1. Duplicate statement 2. This facility is reporting to the covid site. 3. Duplicate comment 4. Duplicate comment 5. Duplicate comment 6. Duplicate comment 7. Duplicate comment 8. Duplicate comment 9. Duplicate comment Continue to page 17	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	7020	A. BUILDING: _____ B. WING _____	C 08/09/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARLER MANOR	3712 GENERAL PATCH ST NE ALBUQUERQUE, NM 87111

(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 033	Continued From page 16 10. No residents were being tested prior to admission or during routine surveillance testing, because no one had covid at the time. 11. Staff were not previously or at the time of this survey being routinely tested for Covid. 12. Previous to R #1 moving in and at the time of this survey none of the residents/staff had any symptoms. 13. Only family were being allowed to visit residents. 14. On 12/15/20 the Co-Owner (husband) became symptomatic and was hospitalized for Covid. 15. On 12/17/20 R #1's family removed [redacted] from the facility with no notice. Administrator/ Owner and other 2 residents were tested for Covid by HH nurse and they all tested positive. 16. R #1 [redacted] 20. 17. R #2 [redacted] 20. 18. R #6 [redacted] 20. D. On 08/05/21 at 2:15 pm, during an interview with R #1's HH nurse, she stated that resident was receiving nursing, physical, and occupational therapy visits at the facility and does not believe at that time the facility was screening visitors. E. On 08/06/21 at 11:30 am, during an interview with R #1's [redacted] stated that on the 1st day (12/03/21) both [redacted] into the facility and [redacted] was able to visit for 8-10 hours a day, until about the 3rd day. Then the owner did not want them to visit, and the number and length of the visits began to decrease after [redacted] tested positive for Covid. According to R #1's [redacted] neither the Administrator/Owner and/or Co-Owner wore a mask in the facility. F. On 08/09/21 at 12:48 pm, during at interview	A 033	Continued from page 16 Narrative comment C. 10. Duplicate comment *All residents vaccinated* 11. Duplicate comment 12. Duplicate comment 13. Duplicate comment 14. Duplicate comment 15. Duplicated comment D. Narrative Comment Duplicate comment E. Narrative comment In remark to R#1 [redacted] not being able to visit The 3rd day was the 6th of Dec and [redacted] was waiting for [redacted] results from the covid test R#1 [redacted] was staying with [redacted] and had to be quarantined as well Continue to page 18	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	7020	A. BUILDING: _____ B. WING _____	C 08/09/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARLER MANOR	3712 GENERAL PATCH ST NE ALBUQUERQUE, NM 87111

(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 033	Continued From page 17 with the Administrator/Owner, she confirmed that they were not using the screening sheets at the time R #1 was a resident. She stated that temperatures were being taken and she was screening verbally, but confirmed there was no documentation available for review. According to the Administrator/Owner R #1's [redacted] got Covid on [redacted]/20. G. On 08/09/21 at 1:06 pm, during an interview with the Administrator/Owner , she confirmed that staff (Administrator/Owner, Co-Owner and 1 helper) at the time were not wearing masks or PPE during this time because there was no covid in the building. When family visited, they had to wear masks when they came in, their temperatures would be taken, if no temp they could visit, and they could not take masks of in the resident's room. R #1's [redacted] was allowed to continue to visit, because [redacted] tested negative for Covid. The Administrator stated that she told R #1's [redacted] that [redacted] could not come in to visit again for 14-days.	A 033	Continued from page 17 F. Narrative comment Covid Screening questions were being asked at the time of entrance into the facility and temperatures were taken at sign in Corrective Action: Questions sheets are being signed and stored with sign in sheets This action of having signatures began during survey. R#1 [redacted] called on 12/4/2020 and said [redacted] 2020 she tested for covid. On Monday 12/7/2020 [redacted] in while the doctor and nurse were seeing R#1. Doctor and nurse would not let [redacted] in the room. [redacted] sat in the foyer for a short time, then left. R#1 [redacted] sent me a copy of [redacted] positive covid test on 12/11/2020	8/3/2021
A 035	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	A 035	Continue to page 19	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	7020	A. BUILDING: _____ B. WING _____	C 08/09/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARLER MANOR	3712 GENERAL PATCH ST NE ALBUQUERQUE, NM 87111

(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 18	A 035	Continued from page 18	

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 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

Continue to page 20

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	7020	A. BUILDING: _____ B. WING _____	C 08/09/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARLER MANOR	3712 GENERAL PATCH ST NE ALBUQUERQUE, NM 87111

(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 19 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 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	A 035	Continued from page 19 Continue to page 21	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	7020	A. BUILDING: _____ B. WING _____	C 08/09/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARLER MANOR	3712 GENERAL PATCH ST NE ALBUQUERQUE, NM 87111

(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 20	A 035	Continued from page 20	

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:
(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

Continue to page 22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	7020	A. BUILDING: _____ B. WING _____	C 08/09/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARLER MANOR	3712 GENERAL PATCH ST NE ALBUQUERQUE, NM 87111

(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 21 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: 7.8.2.35 G (5) Based on record review and interview the facility failed to ensure for 3 (R #s 3-5) of 5 (R #s 1-5) residents whose Medication Administration Records (MARs) were reviewed for compliance that they included both the brand and generic names for all medications. This deficient practice could likely result in the residents being at risk of harm, if the Direct Care Staff (DCS) who assist residents with the self-administration of medications do not know or recognize the generic/brand names of the medications and errors occur due to this vital information missing on the MAR. The findings are: A. Record review of R #3's 08/01/21 through 08/03/21 MAR, revealed that it did not include both the brand/generic names for: [redacted] B. Record review of R #4's 08/01/21 through 08/03/21 MAR, revealed that it did not include both the brand/generic names for: [redacted]	A 035	Continued from page 21 Requirement 7.8.2.35 G5 Medication Record MARS G5. the name of the medication including the drug product name and the generic name Narrative Comment The facility makes up the MARS for each resident by the name of the medication from the pharmacy on the label of the medication container. Deficient Practice Narrative This statement implies that it could likely result in the residents being at risk of harm,which is unfounded In the future the facility ensures compliance that all MAR records shall be written properly for all medications (brand/generic name) Action was taken aftger complaint survey in each current resident records R#3,4,&5 A. In the future the facility ensures compliance that all MAR records shall be written properly for all medications . (brand/generic name) Action was taken after complaint survey in current resident record R#3 *Quality checks will be recorded after the first of each* month and stored in the individuals files by administrator Master Calendar will be notated when QC is to be completed by administrator Continue to page23 B. Record review continued to page 23	8/3/2021 8/3/2021 4/7/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	7020	A. BUILDING: _____ B. WING _____	C 08/09/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARLER MANOR	3712 GENERAL PATCH ST NE ALBUQUERQUE, NM 87111

(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 22 [redacted] C. Record review of R #5's 08/01/21 through 08/03/21 MAR revealed that it did not include both the brand/generic names for: [redacted] D. On 08/03/21 at 12:35 pm, during an interview with the Administrator/Owner, she confirmed that the 08/01/21 through 08/03/21 MARs for R #s 3-5 did not include both the Brand/Generic names for the above listed medications.	A 035	Continued from page 22 B. Record review In the future the facility ensures compliance that all MAR records shall be written properly for all medications as stated above. (brand/generic names) Action was taken after complaint survey in current resident record R#4 Quality checks will be recorded after the first of each month and stored in the individuals files by administrator Master Calendar will be notated when QC to be completed by administrator C. Record review In the future the facility ensures compliance that all MAR records shall be written properly for all medications as stated above. (brand/generic names) Action was taken after complaint survey in current resident record R# 5 Quality checks will be recorded after the first of each month and stored in the individuals files by administrator Master Calendar will be notated when QC to be completed by administrator D. In the future the facility ensures compliance that all MAR records shall be written properly for all medications as stated above. (brand/generic names) Action was taken after complaint survey in each current resident record R# 3,4,&5 Quality checks will be recorded after the first of each month and stored in the individuals files by administrator Master Calendar will be notated when QC to be completed by administrator	8/3/2021 4/7/2022 8/3/2021 4/7/2022 8/3/2021 4/7/2022