STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROV DER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	4047	A. BUILDING: _____ B. WING _____	C 10/26/2022

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

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A 000	Initial Comments The following deficiencies were cited during a Complaint survey completed on 10/26/22, for the state requirements of 7.8.2 NMAC Regulations for Assisted Living Facilities for Adults. Complaint Intake ID #NM00055167 was unsubstantiated with no deficiencies cited. Complaint Intake ID #NM00056573 was substantiated with deficiencies cited. Complaint Intake ID #NM00057458 was unsubstantiated with deficiencies cited. Complaint Intake ID #NM00057562 was substantiated with deficiencies cited. Complaint Intake ID #NM00057702 was substantiated with deficiencies cited. Complaint Intake ID #NM00061216 was unsubstantiated with deficiencies cited. Complaint Intake ID #NM00062160 was substantiated with deficiencies cited. ABBREVIATIONS: 1. Resident: R 2. New Mexico: NM 3. Assisted Living Facility: ALF 4. Memory Care Unit: MCU 5. Direct Care Staff: DCS 6. Resident Assistants: RA 7. Health Care Coordinators: HCC 8. Director of Health Services: DHS 9. Activities of Daily Living: ADLs 10. Individual Service Plan: ISP 11. History and Physical: H&P 12. Power of Attorney: POA 13. Incident Report: IR 14. Registered Nurse: RN 15. Licensed Practical Nurse: LPN 16. Certified Nurse Practitioner: CNP 17. Physicians Extender: PE 18. Policy and Procedure: P/P	A 000		

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A 000	Continued From page 1 19. Emergency Medical Services: EMS 20. Emergency Room: ER 21. Centimeters: cm 22. Fahrenheit: F 23. Fluid ounces: Fl. oz 24. New Mexico Administrative Code: NMAC 25. New Mexico Department of Health - Division of Health Improvement: NM DOH - DHI 26. Community Based Care: CBC	A 000		
A 017	7 NMAC 8.2.17 Staff Training STAFF TRAINING: A. Training and orientation for each new employee and volunteer that provides direct care shall include a minimum of sixteen (16) hours of supervised training prior to providing unsupervised care for residents. B. Documentation of orientation and subsequent trainings shall be kept in the personnel file at the facility. C. Training shall be provided at orientation and at least twelve (12) hours annually, the orientation, training and proof of competency shall include: (1) fire safety and evacuation training; (2) first aid; (3) safe food handling practices (for persons involved in food preparation), to include: (a) instructions in proper storage; (b) preparation and serving of food; (c) safety in food handling; (d) appropriate personal hygiene; and (e) infectious and communicable disease control; (4) confidentiality of records and resident information; (5) infection control; (6) resident rights; (7) reporting requirements for abuse, neglect or exploitation in accordance with 7.1.13 NMAC;	A 017	A) Direct Care Staff #12, and #13 files were reviewed and after reviewing the records both had documented training of resident rights. Staff #12 was hired and trained on resident rights on 08/19/22. Staff #13 was hired on 07/28/22 and trained on resident rights on 08/20/22. B) Business Office Manager and/or designee will conduct an audit of all employee files for compliance with training requirements. Employees out of compliance with trainings will receive a written notice with a time frame of 20 days to complete all trainings. Employees not meeting compliance after 20 days will be removed from the schedule until all trainings have been completed. C) The Business Office Manager will utilize the facility training grid and individual training transcripts to monitor and ensure that all required trainings are completed in a timely manner. D) The training grid will be reviewed during the monthly CQI (Continuing Quality Improvement) Meeting by the Executive Director, Administrator and the department managers	12/16/22

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A 017	Continued From page 2 (8) smoking policy for staff, residents and visitors; (9) methods to provide quality resident care; (10) emergency procedures; (11) medication assistance, including the certificate of training for staff that assist with medication delivery; and (12) the proper way to implement a resident ISP for staff that assist with ISPs. D. If a facility provides transportation to residents, employees of the facility who drive vehicles and transport residents shall have training in transportation safety for the elderly and disabled, including safe vehicle operation. [7.8.2.17 NMAC - Rp, 7.8.2.17 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.17 C. (6) Based on record review and interview, the facility failed to ensure that the Direct Care Staff (DCS) received the required resident rights training at orientation and annually and that there was documentation of completion/competency in their personnel files. This deficient practice could likely result in the 62 (R #s 1-62) residents identified on the census list provided by the Administrator on 10/14/22, to be at risk for harm, illness, or injury, if the DCS are not trained on protecting resident rights. The findings are: A. Record review of DCS #12's training report (date of hire 08/19/22), revealed there was no documentation that resident rights training had been completed.	A 017		

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A 017	Continued From page 3 B. Record review of DCS #13's training report (date of hire 07/28/21), revealed there was no documentation that resident rights training had been completed. C. On 10/31/22 at 12:42 pm, the above findings were confirmed with the Administrator.	A 017		
A 019	7 NMAC 8.2.19 Staffing Ratios STAFFING RATIOS: The following staffing levels are the minimum requirements. A. The facility shall employ the sufficient number of staff to provide the basic care, resident assistance and the required supervision based on the assessment of the residents ' needs. (1) During resident waking hours, facilities shall have at least one (1) direct care staff person on duty and awake at all times for each fifteen (15) residents. (2) During resident sleeping hours, facilities with fifteen (15) or fewer residents shall have at least one (1) direct care staff person on duty, awake and responsible for the care and supervision of the residents. (3) During resident sleeping hours, facilities with sixteen (16) to thirty (30) residents shall have at least one (1) direct care staff person on duty and awake at all times and at least one (1) additional staff person available on the premises. (4) During resident sleeping hours, facilities with thirty-one (31) to sixty (60) residents shall have at least two (2) direct care staff persons on duty and awake at all times and at least one (1) additional staff person immediately available on the premises. (5) During resident sleeping hours, facilities with more than sixty-one (61) residents shall have at	A 019	Resident Care Coordinator (RCC) will be scheduled to receive training specific to using our company sponsored scheduling program to complete the Health Services department staff schedule monthly and updated with changes as they occur, including assigning agency staff to the the company sponsored scheduling program. The Resident Care Coordinator will ensure that Health Services staff are scheduled to meet state staffing requirements at all times. Ongoing monitoring for compliance will be met through review of the daily Health Services staffing schedule each morning during the management stand-up meeting. Further compliance to ensure state staffing requirements are met will be review of the monthly schedule as part of monthly Continuing Quality Improvement. (CQI)	12/16/22

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A 019	Continued From page 4 least three (3) direct care staff persons on duty and awake at all times and one (1) additional staff person immediately available on the premises for each additional thirty (30) residents or fraction thereof in the facility. B. Upon request of the department, the facility shall provide the staffing ratios per each twenty-four (24) hour day for the past thirty (30) days. [7.8.2.19 NMAC - Rp, 7.8.2.18 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.19 A (1) Based on observation, record review, and interview, the facility failed to ensure, that there was enough Direct Care Staff (DCS) on duty on all shifts to provide the basic care, resident assistance and the required supervision based on the assessment of the residents' needs. This deficient practice could likely negativity effect the safety and welfare of the 62 (R #s 1-62) residents identified on the resident census provided by the Administrator on 10/14/22, to be at risk of harm, injury if there are not adequate staffing available to assist residents. The findings are: A. On 10/14/22 at 10:20 am, during observation of the facility, it was observed that there was both an Assisted Living and Memory Care Unit, that were separated by secured doors. B. Record review of the facility census dated 10/14/22, revealed there were 46 residents in the Assisted Living (AL) and 16 residents in the	A 019		

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A 019	Continued From page 5	A 019		

Memory Care Unit (MCU) for a total of 62 residents, which would require the following minimum number of DCS: the facility should have at least:
1. Two staff during wake hours in the MCU.
2. One staff awake and on duty and 1 staff person immediately available and on the premises during sleeping hours in the MCU.
3. 4 staff during wake hours in the AL.
4. Two staff awake and on duty and 1 staff person immediately available and on the premises during sleeping hours in the AL.

Findings related to number of DCS on schedule:

C. Record review of the staff schedule dated 09/01/22 through 10/14/22, revealed:
1. On 09/25/22, for the facility, there was one (1) DCS scheduled in AL from 10:00 pm to 6:00 am. Leaving MCU unattended.
2. On 10/02/22, for the facility, there was one (1) DCS scheduled in AL from 10:00 pm to 6:00 am. Leaving MCU unattended.
3. On 10/09/22, for the facility, there was one (1) DCS scheduled in AL from 10:00 pm to 6:00 am. Leaving MCU unattended.

D. Record review of an outside contracted Staffing Agency employee schedule provided by the Administrator revealed:
1. On 10/02/22, there was one staff that filled in from 10:00 pm to 6:20 am, no information was provided on if they worked in Assisted Living or Memory Care.
2. On 10/03/22, there was one staff that filled in from from 10:30 pm to 6:00 am but no information was provided on if they worked in Assisted Living or Memory Care.

E. On 10/17/22 at 1:35 pm, during an interview

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A 019	Continued From page 6	A 019		

with Anonymous Resident, she stated:
1. Regarding pendant response times, resident states that most times they will answer her call, but often times they don't and its because there are not enough staff to help.

F. On 10/17/22 at 2:20 pm, during an interview with R #8, [redacted] stated:
1. DCS help[redacted] when [redacted] needs it, but often times they do not respond on time especially during the weekends because there is not enough staff.
2. On an unknown date around 4:00 am [redacted] needed help for pain, and [redacted] utilized [redacted] pendant, but they did not respond to [redacted] call. Therefore, [redacted] stated managed/worked through the pain, it eventually passed, and [redacted] did not request further assistance from the DCS.
3. On an unknown date, a care staff told [redacted] that they could not respond on time because there was not enough help.

G. On 10/18/22 at 10:15 am, during an interview with R #6, [redacted] stated:
1. Sometimes DCS do not respond to [redacted] call light because they are doing something else.

H. On 10/20/22 at 11:36 am, during an interview with DCS #10, she stated:
1. The facility would often work with two or even one DCS during night shift (10:00 pm - 6:00 am) for both Assisted Living and Memory Care.
2. On nights that the facility was short staffed, they would have multiple falls in one night.
3. It sometimes takes longer than 15 minutes to respond to resident pendant call lights due to short staffing and sometimes being on the other side of the facility helping another resident.
4. DCS #10 could not recall exact dates or times of the incidents described above.

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A 019	Continued From page 7 I. On 10/20/22 at 12:39 pm, during an interview with DCS #11, she stated: 1. Management at the facility has put the building on two people at night (10:00 pm - 6:00 am). 2. She has called the Administrator and two Supervisors to do something about there not being enough staff. 3. At one moment, there was only one person working throughout the whole building for Assisted Living and Memory Care but could not recall the exact date. 4. Sometimes there's not enough staff to provide care in accordance to resident care plans and there have been times were they had to pass showers over to the next shift. 5. There are residents who require to be turned every two hours and sometimes that does not occur on time. 4. She quit working at the facility because of how the facility is staffing them. J. On 10/20/22 at 1:05 pm, during an interview with Med Aide #1, she stated: 1. She just recently put in her two weeks' notice because of staffing reasons. 2. The Administrator is leaving only one DCS on the Assistant Living side and only one on the Memory Care. 3. She had worked memory care at one time by herself because there was a call in. 4. At times, caregivers have to go back and forth from Assisted Living to Memory Care to help each other since they are short on each side. 5. There have been multiple falls at night because there is not enough staff to help. K. On 10/20/22 at 1:47 pm, during an interview with R #11's POA, [redacted] stated: 1. The facility did not have enough staff to	A 019		

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A 019	Continued From page 8 provide care and we're always short staffed. 2. The staff on multiple occasions did not respond to the residents pendant call light on time, resulting in multiple falls. 3. After one of the resident's falls, he was told by the head nurse that the reason DCS took a while to respond to the residents call was due to being short staffed. 4. He moved the resident to another facility due to the concerns of staffing and multiple falls. L. On 10/26/22 at 8:50 am, during an exit interview with the Director of Health Services, she confirmed that the facility is at times short staffed,	A 019		
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;	A 020	A) An addendum to the Resident Agreement has been prepared using language directly from the Senate Bill (SB) 0335-2013 and been implemented on 10/26/22 by the Administrative Assistant and Director of Sales and Outreach. The addendum was prepared and mailed to all existing residents/family members/Power of Attorney's/Guardians for review and signature with a self-addressed, stamped envelope for easy return. The Director of Sales and Marketing is respons ble for monitoring that all addendum's are returned. The management team will review the return checklist daily in the morning Stand-up meeting. B) The same addendum as above has been added to our Residency Agreement package for review and signature at admission.	12/16/22

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A 020	Continued From page 9 (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; (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.	A 020		

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A 020	Continued From page 10 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 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	A 020		

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A 020	Continued From page 11	A 020		

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 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,

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A 020	Continued From page 12 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] This REQUIREMENT is not met as evidenced by: ADMISSION And DISCHARGE 7.8.2.20 A. (5) This is a repeat/uncorrected deficiency from surveys dated 03/08/21, 10/13/21, and 10/06/22. Refer to Senate Bill (SB) 0335 - 2013 AN ACT RELATING TO HEALTH CARE; REQUIRING CONTRACTS FOR ASSISTED LIVING FACILITIES TO CONTAIN A REFUND POLICY UPON TERMINATION OF A CONTRACT DUE TO THE DEATH OF THE RESIDENT; PROVIDING FOR STORAGE OF A RESIDENT'S BELONGINGS; DECLARING AN EMERGENCY. BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF NEW MEXICO: SECTION 1. A new section of the Public Health Act is enacted to read: "ASSISTED LIVING FACILITIES CONTRACTS--LIMIT ON CHARGES AFTER RESIDENT DEATH.-- A. The contract for each resident of an assisted living facility shall include a refund policy to be implemented at the time of a resident's death. The refund policy shall provide that the resident's	A 020		

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	4047	A. BUILDING: _____ B. WING _____	C 10/26/2022

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A 020	Continued From page 13	A 020		

estate or responsible party is entitled to a prorated refund based on the calculated daily rate for any unused portion of payment beyond the termination date after all charges have been paid to the licensee. For the purpose of this section, the termination date shall be the date the unit is vacated by the resident due to the resident's death and cleared of all personal belongings.
B. If a resident's belongings are not removed within one week of the resident's death and the amount of belongings does not preclude renting the unit, the facility may clear the unit and charge the resident's estate for moving and storing the items at a rate equal to the actual cost to the facility, not to exceed ten percent of the regular rate for the unit; provided that the responsible party for the resident is given notice at least one week before the resident's belongings are removed. If the resident's belongings are not claimed within forty-five days after notification, the facility may dispose of them.
C. For the purposes of this section, "assisted living facility" means a facility required to be licensed as an assisted living facility for adults by the department of health."
SECTION 2. EMERGENCY.--It is necessary for the public peace, health and safety that this act take effect immediately.

Based on record review and interview, the facility failed to ensure for 2 (R #s 3 & 4) of 11 (R #s 1-11) residents whose records were reviewed for compliance that the Admission and Discharge Agreements included a complete refund provision in case of death that is in compliance with 7.8.2.20 NMAC Regulations for Assisted Living Facilities For Adults and the Senate Bill (SB) 0335 - 2013.

These deficient practices could potentially affect

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A 020	Continued From page 14 the health, safety, and welfare of the residents if the resident's guardian and/or Power of Attorney are not aware of receiving monies owed or aware of additional charges that may be incurred upon the resident's death. The findings are: A. Record review of the following resident's Admission and Discharge agreements (Rev. 2/20/19), revealed the agreement did not include a complete refund provision in case of death: 1. R #3's Admission/Discharge agreement dated [redacted]/21, was missing the information according to Senate Bill (SB) 0335 - 2013 in section B. 2. R #4's Admission/Discharge agreement dated [redacted]/21, was missing the information according to Senate Bill (SB) 0335 - 2013 in section B. B. On 10/19/22 at 11:34 am, during an interview with the facility's Director of Health Services, she confirmed that the above residents Admission and Discharge agreements did not include a complete refund provision in case of death.	A 020		
A 021	7 NMAC 8.2.21 Resident Records RESIDENT RECORDS: A. Record contents. A record for each resident shall be maintained in accordance with the specific requirements of this section. Entries in each resident's record shall be legible, dated and authenticated by the signature of the person making the entry. Resident records shall be readily available on site and organized utilizing a table of contents. Each resident record shall include: (1) the admission agreement records, as set forth in 7.8.2.20 NMAC;	A 021	A)Ancillary outside services policy has since been implemented and will be included in the 12/9/22 staff meeting for all RCC Resident Care Coordinator Healthcare Coordinators(HCC) and Director of Health Services DHS will ensure implementation until all staff training date. B)Train front deck on Ancillary companies process for entrance into building and communication with clinical team. C) DHS will train RCC on entering outside ancillary service notes in PCC. DHS will train HCC and RCC staff on the triple check process. D) A list of residents receieving Ancillary services will be reviewed in CQI monthly.	12/16/22

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A 021	Continued From page 15 (2) the resident evaluation form, that is to be completed within fifteen (15) days prior to admission and updated at a minimum of every six (6) months; (3) the current ISP, that is to be completed within ten (10) calendar days of admission and updated at a minimum of every six (6) months; (4) the physical examination report; the physical examination report shall have been completed within the past six (6) months, by a primary care physician, a nurse practitioner or a physician ' s assistant and shall be on file in the resident ' s record within ten (10) days of admission; (5) personal and demographic information for the resident, to include: (a) current names, addresses, relationship and phone numbers of family members, or surrogate decision makers updated as necessary; (b) resident's name; (c) age; (d) recent photograph; (e) marital status; (f) date of birth; (g) sex; (h) address prior to admission; (i) religion (optional); (j) personal physician; (k) dentist; (l) social history; (m) surrogate decision maker or other emergency contact person; (n) language spoken and understood; (o) legal documentation relevant to commitment or guardianship status; (p) current medications list; and (q) required diet; (6) unless included in the admission agreement, a separate written agreement between the facility and the resident relating to the resident's funds,	A 021		

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A 021	Continued From page 16 in accordance with the facility's policy and procedures; (7) entries by direct care staff, appropriate health care professionals and others authorized to care for the resident; entries shall be dated and signed by the person making the entry and shall include significant information related to the ISP; (8) entries that provide a written account of all accidents, injuries, illnesses, medical and dental appointments, any problems or improvements observed in the resident, any condition that would indicate a need for alternative placement or medical attention and entries reflecting appropriate follow-up; the maintenance of such written documentation in the resident record may be by copy of an incident or accident report, if the original incident or accident report is maintained elsewhere by the facility; (9) the medication assistance record (MAR); the MAR is the document that details the resident's medication; the MAR shall include all of the information pursuant to Subsection G of 7.8.2.35 NMAC of this rule; (10) progress notes completed by any contract agency (e.g., hospice, home health); the progress notes shall include the date, time and type of health services provided; (11) copies of all completed and signed transfer forms from the accepting facility when a resident is transferred to a hospital or another health care facility and when the resident is transferred back to the facility; and (12) upon the death or transfer of a resident, documentation of the disposition of the resident's personal effects and money or valuables that are deposited with the assisted living facility. B. Resident records maintenance. (1) Current resident records shall be maintained on-site and stored in an organized, accessible	A 021		

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A 021	Continued From page 17 and permanent manner. (2) The facility shall establish a policy to maintain and ensure the confidentiality of resident records, including the authorized release of information from the resident records. (3) Non-current resident records shall be maintained by the facility against loss, destruction and unauthorized use for a period of not less than five (5) years from the date of discharge and readily available within twenty-four (24) hours of request. (4) There shall be a policy and procedure in place for record retention in the event of facility closure. (5) Failure to follow facility policies is grounds for sanctions. [7.8.2.21 NMAC - Rp, 7.8.2.22 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: RESIDENT RECORDS 7.8.2.21 A. (10) Based on record review and interview the facility failed to ensure for 1 (R #s 3) of 11 (R #s 1-11) residents whose records were reviewed for compliance had progress notes completed by the contracted agency for the health services which were provided. This deficient practice could likely affect the health, safety, and welfare of residents if the facility does not have pertinent information regarding the health services which were provided. The findings are:	A 021		

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A 021	Continued From page 18 A. Record review of R #3's facility record revealed [redacted] was admitted on [redacted]/21, and there was no documentary evidence of progress notes completed by the Home Health agency which was ordered on 02/22/22. B. On 10/24/22 at 9:18 am, during an interview with the facility's Director of Health Services, she confirmed that R #3's facility record did not have any progress notes completed by the Home Health agency for the health services which were provided.	A 021		
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,	A 025	A)DHS will ensure that pre-admission evaluations are completed by licensed nurse in accordance regulation. B) DHS/Designee will monitor the the schedule for annual medical evaluations and ensure the documentations is filled in medical records. C)DHS/Designee will ensure H&P are obtained prior to admission and entered into PCC so that dashboard alerts will assist with annual medical evaluation completion. D) New resident records will be reviewed in monthly CQI	12/16/22

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A 025	Continued From page 19 etc; (4) vision; (5) physical functioning and skeletal problems; (6) incontinence of bowel/bladder; (7) psychosocial well-being; (8) mood and behavior; (9) activity interests; (10) diagnoses; (11) health conditions; (12) nutritional status; (13) oral or dental status; (14) skin conditions; (15) medication use and level of assistance needed with medications; (16) special treatments and procedures or special 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: RESIDENT EVALUATION	A 025		

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A 025	Continued From page 20 7.8.2.25 D. E. Based on record review and interview, the facility failed to ensure for 2 (R #s 3, 4) of 11 (R #s 1-11) residents whose facility records were reviewed for compliance to ensure that: 1. The resident's initial Evaluation was completed within fifteen (15) days prior to admission. 2. The residents had a medical evaluation completed by a physician or a physician extender at least annually. 3. The resident's Evaluations were reviewed and if needed revised by a Licensed Practical Nurse (LPN), Registered Nurse (RN), or a Physician Extender. These deficient practices could potentially affect the health, safety, and welfare of residents if: 1. The resident's initial baseline evaluation was not done prior to admission to determine the level of assistance needed and if the level of services required can be met by the facility. 2. The resident has not had a recent medical evaluation which provides the facility with the resident's current and past medical diagnoses and health conditions, chronic conditions that need further evaluation and management, medications, limitations, allergies, and demographic information to assist the facility with the resident's baseline Evaluation and developing the Individual Service Plan. 3. The resident's Evaluation was not reviewed by licensed personnel (LPN or RN) or a Physician Extender to verify that the level of assistance that is needed by the resident was: (a) The appropriate level of assistance based on the resident's abilities and behaviors and health status. (b) The Resident Assistants (RA) and the Medication Technicians are knowledgeable and	A 025		

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A 025	Continued From page 21	A 025		

providing the resident with the level of assistance that is required according to the evaluation.

The findings are:

A. Record review of R #3's facility record revealed the following:
1. The facility's admission date was [redacted]/21, and the initial baseline admission evaluation was done on [redacted]/21.
2. The facility's admission date was [redacted]/21, and the admission H&P was done on [redacted]/21, however there was no documentary evidence that an annual medical evaluation for 2022 was done.
3. The following Evaluations dated 08/20/21 and 09/19/21, had no documentary evidence that the Evaluation was reviewed by a LPN, RN, or a Physician Extender.

B. Record review of R #4's facility record revealed the following:
1. The facility's admission date was [redacted]/21, and the admission H&P was done on [redacted]/20, however there was no documentary evidence that an annual medical evaluation for 11/2021 was done.
2. The following Evaluations dated 02/08/21, 03/23/21, 04/19/21, 07/12/21, 11/26/21, and 02/07/22, had no documentary evidence that the Evaluation was reviewed by a LPN, RN, or a Physician Extender.

C. On 10/19/22 at 11:34 am, during an interview with the facility's Director of Health Services (DHS), she confirmed the facility's form labeled "CBC Level of Care Evaluation - NM" is considered the residents Evaluation form. The DHS confirmed the above findings for R #3 and 4.

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A 026	Continued From page 22	A 026		
A 026	7 NMAC 8.2.26 Individual Service Plan INDIVIDUAL SERVICE PLAN (ISP): An ISP shall be developed and implemented within ten (10) calendar days of admission for each resident residing in the facility. A. The ISP shall address those areas of need as identified in the resident evaluation and through staff observation. (1) The ISP shall detail the services that are provided by the facility as well as the services to be provided by other agencies. (2) The resident evaluation and the ISP shall be reviewed and if needed revised by a licensed practical nurse, registered nurse or a physician extender. (3) The ISP shall be reviewed and or revised at a minimum of every six (6) months or when there is a significant change in the resident ' s health status. B. The ISP shall include the following: (1) a description of identified needs as noted in the resident evaluation; (2) a written description of all services to be provided; (3) who will provide the services; (4) when or how often the services will be provided; (5) how the services will be provided; (6) where the services will be provided; (7) expected goals and outcomes of the services; (8) documentation of the facility ' s determination that it is able to meet the needs of the resident; (9) the level of assistance that the resident will require with activities of daily living and with medications; (10) a crisis prevention/intervention plan when indicated by diagnosis or behavior; and (11) current orders for all medications, including	A 026	A) After review of residents #3 and #4 medical records ISP's were in place, and had been reviewed and signed by DHS/LPN. B) DHS/LPN will ensure all NM Level of Care evaluations and Individual Service Plans are reviewed and signed within 10 days of completion. C) All diet orders will go through the triple check process, in which the written order is received by the Health Care Coordinator who is responsible for entering the order into our electronic medical record. The order will be stamped with the triple check stamp and initialed by that Health Care Coordinator. The Health Care Coordinator will notify the dietary staff in writing of the resident's diet. The Resident Care Coordinator will review the order and compare it with the written order to ensure accuracy, then initial the triple check stamp for second check of the triple check, then update the service plan. The written order containing the triple check stamp will then be given to the Director of Health Services for final check for accuracy and implementation in the electronic health record, print out the updated diet report with highlighted changes to the dietary department and the ISP. D) Diet report will be reviewed in monthly CQI with highlighted changes from the previous month.	12/16/22

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A 026	Continued From page 23 those authorized for PRN usage. [7.8.2.26 NMAC - Rp, 7.8.2.26 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.26 A. (2) Based on record review and interview the facility failed to ensure for 3 (R #s 2, 3 and 4) of 11 (R #s 1-11) residents whose facility records were reviewed for compliance that: 1. There was an updated Individual Service Plans (ISPs) to address areas of need as identified in the resident evaluation. 2. The ISPs were reviewed and if needed revised by a Licensed Practical Nurse (LPN), Registered Nurse (RN), or a Physician Extender. These deficient practices could potentially affect the health, safety, and welfare of residents if: 1. The Direct Care Staff are not aware of specific resident needs as identified in the resident evaluation. 2. Their ISPs are not reviewed by licensed personnel (LPN or RN) or a Physician Extender to verify that: (a) The facility is providing the resident appropriate level of assistance with ADLs based on the resident's abilities and behaviors and health status according to the evaluation and ISP. (b) The facility is providing the appropriate services the resident needs and any services needed by other agencies. The findings related to R #2 are: A. Record review of R #2's [redacted] (dated 03/16/22),	A 026		

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A 026	Continued From page 24 revealed that it did not contain updated Diet Order and Dining Ability information from the Community Based Care (CBC) Nutritional Assessment (dated 03/09/22). B. Record review of R #2's Physicians Order (dated [redacted]/21) revealed that the resident was prescribed a [redacted] The findings related to R #3 and 4 are: C. Record review of R #3's [redacted] dated 08/20/21, 10/04/21, 01/19/22, and 02/23/22, had no documentary evidence that the [redacted] were not reviewed and if needed revised by a LPN, RN, or a Physician Extender. D. Record review of R #4's ISPs dated 07/19/21, 11/01/21, 02/10/22, 04/19/22 and 07/20/22, had no documentary evidence that the [redacted] were not reviewed and if needed revised by a LPN, RN, or a Physician Extender. E. On 10/26/22 at 8:50 am, during an interview at the exit conference with the facility's Director of Health Services, she confirmed that: 1. R #2's [redacted] dated [redacted]/22 did not contain updated information as identified in the CBC Nutritional Assessment as per the Physicians Order dated 10/21/21. 2. R #3 and 4's ISPs indicated above had no documentary evidence that the [redacted] were not reviewed and if needed revised by a LPN, RN, or a Physician Extender.	A 026		
A 032	7 NMAC 8.2.32 Reporting of Incidents REPORTING OF INCIDENTS: A. The facility shall insure that all suspected	A 032		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 032	Continued From page 25 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] This REQUIREMENT is not met as evidenced by: REPORTING OF INCIDENTS 7.8.2.32 A. (1) - (2), B. (1) - (3) 7.1.13 INCIDENT REPORTING, INTAKE, PROCESSING AND TRAINING	A 032	A)On 10/28/2022 the Director of Health Services reviewed the regulations referencing 7.1.13 INCIDENT REPORTING, INTAKE, PROCESSING AND TRAINING REQUIREMENTS to ensure understanding of the specific regulations and ensure corrections are made for future compliance with reporting. B)On 11/22/22 during bimonthly all staff in-service training, the Executive Director/DHS and Administrator provided full training with handout and question and answer period regarding 7.1.13 INCIDENT REPORTING, INTAKE, PROCESSING AND TRAINING REQUIREMENTS. C)The Executive Director and the Business Office Manager will utilize the training grid to monitor and ensure all employees receive the required initial and annual training for incident reporting. D)All incidents will be reviewed by the management team each morning at the daily Stand-up meeting to ensure incidents meeting criteria for state reporting is completed within 24 hours or the next business day if on a weekend or holiday. The Executive Director and the Director of Health Services will be responsible to ensure the facility completes a thorough investigation and submits a written report to the Department of Health within 5 business days. E)Incidents are reviewed in CQI monthly.	12/16/22

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A 032	Continued From page 26 REQUIREMENTS Refer to 7.1.13.7 W, 8 B. (2), 10 C. W. "Reportable incident" means possible abuse, neglect, exploitation, injuries of unknown origin and other events including but not limited to falls which cause injury, unexpected death, elopement, medication error which causes or is likely to cause harm, failure to follow a doctor's order or an ISP, or any other incident which may evidence abuse, neglect, or exploitation. B. (2) Division incident report form and notification by licensed health care facilities: The licensed health care facility shall report incidents utilizing the division's incident report form consistent with the requirements of the division's incident management system guide and CMS regulations as applicable. The licensed health care facility shall ensure that all incident report forms alleging abuse, neglect, exploitation, injuries of unknown origin or other reportable incidents are submitted by a reporter with direct knowledge of an incident, are completed on the bureau's incident report form and received by the division within twenty-four (24) hours of an incident or allegation of an incident or the next business day if the incident occurs on a weekend or a holiday. The licensed health care facility shall ensure that the reporter with the most direct knowledge of the incident assists with the preparation of the incident report form. C. All licensed health care facilities shall conduct a complete investigation and report the actions taken and conclusions reached by the facility within five (5) days of discovery of the incident. [7.1.13.10 NMAC - Rp, 7.1.13.11 NMAC, 7/1/14]	A 032		

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A 032	Continued From page 27	A 032		

Based on record review and interview, the facility failed to ensure for 5 (R#'s 3, 4, 5, 6 and 11) of 11 (R #1-11) residents whose records Internal Incident Reports (IRs) were reviewed for compliance for any possible abuse, neglect, exploitation, injuries of unknown origin and other events including but not limited to falls which cause injury were:
1. Reported to the Licensing Authority within 24 hours or the next business day if it is a weekend or a holiday.
2. The facility conducted and documented the investigation of all reportable incidents within five (5) business days and submit a copy of the investigation report to the Licensing Authority.

These deficient practices could potentially result in the 62 (R #s 1-62) residents listed on the census provided by the facility's Administrator on 10/14/22, to be at risk of harm, injury, and/or death, due to the facility failing to report any "Reportable incident" to the Licensing Authority for oversight.

The findings related R #3 and 4 are:

A. Record review of the facility's Internal Incident Reports (IRs) for R #3 revealed:
1. According to the facility's Internal IR dated 02/18/22, R #3 was found in [redacted] room on [redacted] in front of [redacted] and was unable to recall how [redacted] The Direct Care Staff (DCS) assisted R #3 up into his wheelchair and took [redacted] vital signs, in which [redacted] Blood Pressure (B/P) was noted to be very low. R #3 was sent to a local Hospital's Emergency Room (ER) for further evaluation and was admitted for [redacted] On [redacted]/22, R #3 was released from the hospital back to the facility.

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A 032	Continued From page 28 2. According to the facility's Internal IR dated 03/01/22, the medication aide walked into R #3's bedroom and found [redacted] lying on the floor on [redacted] just outside of [redacted] bathroom facing away from the bathroom, [redacted] walker was beside [redacted] and [redacted] was wearing shoes and socks. R #3 reported to the medication aide that when [redacted] was leaving [redacted] bathroom, [redacted] was turning [redacted] walker and lost [redacted] balance. The medication aide checked R #3 for visible injuries. According to the Internal IR, R #3, denied any pain, [redacted] was able to communicate, he was able to move [redacted] B. Record review of R #4's facility record revealed: 1. According to the facility's Progress Notes on 01/01/22 at 11:04 am, Direct Care Staff (DCS) notified the facility's nurse that R #4 had a [redacted] DCS noted that R #4 was "able to move [redacted] no redness observed at the moment. Staff to monitor". 2. According to the facility's Progress Notes on 01/30/22 at 12:22 pm, DCS noted that R #4 had a [redacted] of unknown origin covered with bandage, an abrasion to the [redacted] 3. According to the facility's Progress Notes on 01/30/22 at 3:30 pm, the facility's nurse removed R #4's dressing from [redacted] No signs of Infection ...Cleansed with wound wash, pat dry and covered with an adhesive bandage".	A 032		

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A 032	Continued From page 29 C. Record Review of R #3 and 4 facility record's revealed, there was no documentary evidence that the facility reported the above incidents for R #3 and 4, to the Licensing Authority within 24 hours or the next business day if a holiday or weekend and that an internal investigation was conducted within 5 business days and submitted a copy of the investigation report to the Licensing Authority. D. On 10/19/22 at 11:34 am, during an interview with the facility's Director of Health Services, she confirmed that the above incidents for R #3 and 4, were not reported to the Licensing Authority within 24 hours, or the next business day and the facility did not conduct an investigation on the above incidents within five (5) business days. The findings related R #5 are: E. Record review of R #5's facility record, and incident reports revealed: 1. There was an incident report dated 01/15/22 in which it was reported that the resident grabbed another resident, and that resident pushed [redacted] and the resident lost balance and fell to the floor. 2. The resident sustained a quarter-sized, rug burn type injury to her left elbow. F. On 10/25/22 at 1:45 pm, during an interview with Former Med-tech #7, she confirmed: 1. R #5 was yelling at another resident and fell back after the altercation, [redacted] 2. She did not know if the resident was pushed and did not see exactly what caused [redacted] 3. She created an internal incident report. 4. She was not sure if anyone in the facility reported the incident to the Licensing Authority.	A 032		

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A 032	Continued From page 30 G. On 10/26/22 at 8:49 am, during an interview with the DHS, she confirmed: 1. She was not working at the facility at the time of R #5's incident. 2. The incident was not reported to the Licensing Authority. The findings related R #6 and 11 are: H. Record review of intake # NM61216 revealed: 1. An outside source reported an allegation of resident abuse involving R #6 on an unknown date. 2. Report states a staff member pushed the resident down on the toilet leaving [redacted] and on different occasions was yelling at the resident telling [redacted] to move and hurry up back into bed. I. Record request of incident reports for R #6 revealed, there was no documentation that the allegation on intake # NM61216 was reported to the Licensing Authority. J. Record review of R#11's incident report dated 10/06/21 revealed: 1. The resident had an unwitnessed fall and was found on the floor. 2. The resident was complaining of a [redacted] 3. The resident was sent out to the hospital for further evaluation. K. Record request for an external incident report for R #11 revealed there was no documentation that the incident on 10/06/21, involving the resident being sent out to the hospital, was reported to the Licensing Authority. L. On 10/18/22 at 1:57 pm, during an interview	A 032		

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A 032	Continued From page 31 with the Director of Health Services, she confirmed that the allegation of resident abuse involving R #6 on intake NM#61216 was not reported to the Licensing Authority. M. On 10/26/22 at 8:50 am, during an exit interview with the Director of Health Services, she confirmed that the incident involving R#11 on 10/06/21 was not reported to the Licensing Authority.	A 032		
A 033	7 NMAC 8.2.33 Resident Rights RESIDENT RIGHTS: All licensed facilities shall understand, protect and respect the rights of all residents. A. Prior to admission to a facility, a resident and legal representative shall be given a written description of the legal rights of the resident, translated into another language, if necessary, to meet the resident ' s understanding. B. If the resident has no legal representative and is incapable of understanding his or her legal rights, a written copy of the resident's legal rights shall be provided to the most significant responsible party in the following order: (1) the resident's spouse; (2) significant other; (3) any of the resident's adult children; (4) the resident's parents; (5) any relative the resident has lived with for six or more months before admission; (6) a person who has been caring for, or paying benefits on behalf of the resident; (7) a placing agency; (8) resident advocate; or (9) the ombudsman. C. The resident rights shall be posted in a conspicuous public place in the facility and shall	A 033	A)A new pest control company has been contracted, and we are on a routine service plan. 11/03/22 new company gave documentation of guarantee of pest service. B)Our facility does not and will not use physical restraints. All staff will receive re-education of resident rights. C)DHS terminated the staff that violated resident rights. Staff will be reeducated on resident rights. D)RCC/DHS will in-service caregivers and HCC on ISP and following ISP while providing care. Environmental Services manager will report pest control services and issues in CQI monthly. DHS reviews clinical dashboard data in CQI monthly.	12/16/22

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A 033	Continued From page 32 include the telephone numbers for the incident management hotline and for the state ombudsman program. D. To protect resident rights, the facility shall: (1) treat all residents with courtesy, respect, dignity and compassion; (2) not discriminate in admission or services based on gender, sexual orientation, resident's age, race, religion, physical or mental disability, or nationality; (3) provide residents written information about all services provided by the facility and their costs and give advance written notice of any changes; (4) provide residents with a safe and sanitary living environment; (5) provide humane care for all residents; (6) provide the right to privacy, including privacy during medical examinations, consultations and treatment; (7) protect the confidentiality of the resident ' s medical record; (8) protect the right to personal privacy, including privacy in personal hygiene; privacy during visits with a spouse, family member or other visitor; and privacy in the resident's own room; (9) protect the right to communicate privately and freely with any person, including private telephone conversations and private correspondence; and the right to receive visits from family, friends, lawyers, ombudsmen and community organizations; (10) prohibit the use of any and all physical and chemical restraints; (11) ensure that residents: (a) are free from physical and emotional abuse neglect and misappropriation/or exploitation; (b) are free from financial abuse and misappropriation by facility staff or management; (c) are free to participate in religious, social,	A 033		

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community and other activities and freely associate with persons in and out of the facility;
(d) are free to leave the facility and return without unreasonable restriction;
(e) are given a fifteen (15) calendar day, written notice before room transfers or discharge from the facility unless there is immediate danger to self or others in the facility;
(f) have an environment that fosters social interaction and avoids social isolation;
(g) or their surrogate decision makers, are informed of and consent to the services provided by the facility;
(h) have the right to voice grievances to the facility staff, public officials, the ombudsmen, any state agency, or any other person, without fear of reprisal or retaliation;
(i) have the right to have their complaints addressed within fourteen (14) calendar days or sooner;
(j) have the right to participate in the development of their care plan/ISP;
(k) have the right to choose a doctor, pharmacist and other health care provider(s);
(l) have the right to participate in medical treatment decisions and formulate advance directives such as living wills and powers of attorney;
(m) have the right to keep and use personal possessions without loss or damage;
(n) have the right to manage and control their personal finances;
(o) have the right to freely organize and participate in a resident association that may recommend changes in the facility's policies, services and management;
(p) shall not be required to work for the facility; and
(q) are protected from unjustified room transfers

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A 033	Continued From page 34 or discharge. E. The resident's rights shall not be restricted unless this restriction is for the health and safety of the resident, agreed to by the resident or the resident ' s surrogate decision maker and outlined in the resident ' s individual service plan. [7.8.2.33 NMAC - Rp, 7.8.2.34 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.33 D (4) (10) Based on record review and interview, the facility failed to ensure for 2 (R #3 and 5) of 11 (R #1-11) residents whose records were reviewed for compliance ensured that: 1. The facility provides the residents with a safe and sanitary living environment. 2. The facility prohibits the use of any and all physical restraints. This deficient practice could potentially cause for the 62 (R #1-62) residents identified on the census list provided by the administrator on 10/14/22, to be at risk of harm, injury, or mental anguish if: 1. The residents are exposed to unsanitary conditions from pest/insects and are not monitored frequently to provide the resident with a safe environment. 2. They are unable to move independently and are buckled into a wheelchair. The findings related to R #5 are: A. Record review of intake #56573 revealed R #5 was reported to have been tied to [redacted] wheelchair	A 033		

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A 033	Continued From page 35 by DCS #5 on 01/15/22. B. Record review of the facility self-report form to the Licensing Authority revealed R #5 was reported to have been tied to [redacted] wheelchair by Former DCS #5 on 01/15/22. C. Record review of R #5's Level of Care Service Plan dated 01/14/22, revealed [redacted] required a standard wheelchair (no restraints) to assist with mobility. D. Record review of R #5's Memory Care Level of Care Evaluation dated 12/31/21, revealed [redacted] required a standard wheelchair (no restraints) to assist with mobility. E. Record review of R #5's Physician Orders revealed no order for a wheelchair with a [redacted] F. Record review of a witness statement from Former Med-Tech #7 revealed: 1. On 01/15/22, she saw Former DCS #5 coming from the dining room area toward the living room area with R #5 buckled into the wheelchair. 2. She told Former DCS #5, [redacted] can't be like that," and he unbuckled [redacted] G. On 10/25/22 at 1:45 pm, during an interview with Former Med-Tech #7, she confirmed that on 01/15/22, Former DCS #5 had R #5 buckled into [redacted] wheelchair while transporting [redacted] through the facility. H. Record review of Former Med Tech #9's written statement dated 01/15/22, revealed he witnessed R #5 being buckled into [redacted] wheelchair by Former DCS #5.	A 033		

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I. Record review of Former DCS #8's written statement dated 01/15/22, revealed she witnessed R #5 buckled into [redacted] wheelchair and being transported through the facility by Former DCS #5.

J. On 10/20/22 at 1:42, during an interview for Former DCS #8, she confirmed that R #5 was buckled into [redacted] wheelchair and being transported through the facility by Former DCS #5.

K. On 10/24/22 at 10:20 am, during an interview with the Former Administrator, she confirmed that Former DCS #5 told her he had buckled R #5 into [redacted] wheelchair because he was afraid, [redacted] was going to try and stand up when he was transporting [redacted] through the facility.

The findings related to R #3 are:

L. Record review for the Complaint Intake #57702 for R #3, the following was found regarding Resident Rights that the facility will provide residents a safe and sanitary environment:
1. Review of the facility's Internal Incident Report (IR) dated 02/18/22, R #3 was found by one (1) of the facility's Direct Care Staff (DCS) in [redacted] room on the floor on [redacted] /22. R #3's blood pressure was very low and was transported to a local hospital's emergency room (ER) for further evaluation and was admitted to the hospital for [redacted]
2. Review of the local hospital's records for R #3 for 02/18/22 revealed, that R #3 informed the ER physician that [redacted] had fallen right after the 10:00 pm news on 02/17/22 and was not found by the facility staff until 7:30 am on 02/18/22.
3. Review of the facility's [redacted] /22,

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A 033	Continued From page 37 indicates that the facility staff will be aware of R #3's increased risk for falls related to potential impairment of [redacted] and mobility. 4. Review of the facility's Internal IR dated 03/09/22, R #3 was found by 1 of the facility's DCS on 03/09/22 at 7:00 am unresponsive lying in [redacted] bed on [redacted] with dark coffee ground [redacted] R #3 was transported to a local hospital's ER for further evaluation and was admitted to the hospital. 5. Review of the local hospital's records for R #3 for 03/09/22 revealed, that the Emergency Medical Services (EMS) staff reported that upon arrival to the facility R #3 was "covered in ants". According to the ER physician's notes R #3 was likely not being checked on regularly, due to the severity of [redacted] illness. M. On 10/21/22 at 3:28 pm, during an interview with the facility's Director of Health Services (DHS), she confirmed that for the incident which occurred on 02/18/22, she was hired on 02/07/22 and was not the DHS until 04/16/22. The DHS did confirm that she was made aware of R #3 incident on 03/09/22 and she did the Internal IR, the internal investigation of the incident on 03/09/22 and reported it to the Licensing Authority.	A 033		
A 034	7 NMAC 8.2.34 Custodial Drug Permits CUSTODIAL DRUG PERMITS: A facility with two (2) or more residents that is licensed pursuant to this rule and that assists with self-administration or safeguards medications for residents shall have a current custodial drug permit issued by the state board of pharmacy. A. Procurement, labeling and storage. The facility	A 034		

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A 034	Continued From page 38 shall provide assistance to the resident in obtaining the necessary medications, treatment and medical supplies as identified in the ISP. The facility shall procure, label and store medications for residents who require assistance with self-administration of medication in compliance with state and federal laws. (1) All medications, including non-prescription drugs, shall be stored in a locked compartment or in a locked room, as approved by the board of pharmacy and the key shall be in the care of the administrator or designee. (2) Internal medication shall be kept separate from external medications. Drugs to be taken by mouth shall be separated from all other delivery forms. (3) A separate, locked refrigerator shall be provided by the facility for medications. The refrigerator temperature shall be kept in compliance with the state board of pharmacy requirements for medications. (4) All medications, including non-prescription medications, shall be stored in separate compartments for each resident and all medications shall be labeled with the resident's name. (5) A resident may be permitted to keep his or her own medication in a locked compartment in his or her room for self-administration, if the physician's order deems it appropriate. (6) The facility shall not require the residents to purchase medications from any particular pharmacy. (7) Medical gases (oxygen) and equipment used for the administration of inhalation therapy and for resuscitative purposes shall comply with the national fire protection association (NFPA) 99. (8) A proof of use record shall be maintained separately for each schedule II through IV drug	A 034	A) The facility will follow the regulation related to medication storage. B) The DHS/RCC will ensure that that medications are stored in accordance with regulation. C) Controlled medication will be monitored by DHS, Executive Director and/or Designee. D) DHS and RCC will ensure the medication room and frig temp are monitored and log. E) DHS will report pharmacy report and information related to drug storage/destruction in CQI.	12/16/22

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A 034	Continued From page 39	A 034		

(controlled substances). The proof of use sheet shall document:
(a) the type and strength of the schedule II through IV drugs;
(b) the date and time staff assisted with self-administration;
(c) the resident ' s name;
(d) the prescriber ' s name;
(e) the dose;
(f) the signature of the person assisting with delivery of the medication; and
(g) the balance of medication remaining.
(9) Any remaining medication discontinued by a physician ' s order, or upon discharge or death of the resident shall be inventoried and moved to a separate locked storage container. Such discontinued medications shall be destroyed upon the next quarterly visit by the consulting pharmacist in accordance with 16.19.11.10 NMAC.
(10) The record of medication destruction shall be signed by the administrator or designee and the pharmacist and shall be kept on file at the facility.
B. Consulting pharmacist. The facility shall maintain records demonstrating that the consulting pharmacist provides the following oversight and guidance.
(1) Reviews the medication regimen as needed, but at least quarterly/every three (3) months, to determine that all medications and records are accurate and current. All irregularities shall be reported to the administrator of the facility and these irregularities shall be resolved by the administrator within seventy-two (72) hours.
(2) A system of records of receipt and disposition of all drugs in sufficient detail to enable an accurate reconciliation.
(3) Consultation shall be provided on all aspects

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A 034	Continued From page 40 of pharmacy services in the facility, including reference information regarding side effects and, when needed, physician consultation in cases involving the use of psychotropic medications. (4) The consulting pharmacist will be responsible for assuring that the facility meets all requirements for storage, labeling, destruction and documentation of medications as required by the state board of pharmacy, 16.19.11.10 NMAC and 7.8.2 NMAC. [7.8.2.34 NMAC - Rp, 7.8.2.35 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: CUSTODIAL DRUG PERMITS 7.8.2.34 A. (1) (3) (9) B. (1) Refer to 16.19.11.8 B. (7) (c) (10) (a) PHARMACIST NURSING HOME DRUG CONTROL (7) DRUG CONTROL (a) All state and federal laws relating to storage, administration and disposal of controlled substances and dangerous drugs shall be complied with. (b) Separate sheets shall be maintained for controlled substances records indicating the following information for each type and strength of controlled substances: date, time administered, name of patient, dose, physician's name, signature of person administering dose, and balance of controlled substance in the container. (c) All drugs shall be stored in locked cabinets, locked drug rooms, or state of the art locked medication carts. (d) Medication requiring refrigeration shall be	A 034		

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A 034	Continued From page 41 kept in a secure locked area of the refrigerator or in the locked drug room. (e) All refrigerated medications will be kept in separate refrigerator or compartment from food items. (10) Destruction of dispensed drugs for patients in health care facilities or institutions: (a) The drugs are inventoried, and such inventory is verified by the consultant pharmacist. The following information shall be included on this inventory: (i) name and address of the facility or institution; (ii) name and pharmacist license number of the consultant pharmacist; (iii) date of drug destruction; (iv) date the prescription was dispensed; (v) unique identification number assigned to the prescription by the pharmacy; (vi) name of dispensing pharmacy; (vii) name, strength, and quantity of drug; (viii) signature of consultant pharmacist destroying drugs; (ix) signature of witness(es); and (x) method of destruction. Based on observation and interview, the facility failed to ensure that: 1. All medications, including non-prescription drugs shall be stored in locked cabinets, locked drug rooms, or state of the art locked medication carts. 2. Any medications discontinued by a physician's order, or upon discharge or death of the resident are inventoried and then moved to a separate locked storage container. 3. The temperature for the refrigerator designated for resident's medications shall be kept in compliance with the state board of pharmacy	A 034		

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A 034	Continued From page 42	A 034		

requirements for medications.
4. All irregularities determined by the Consulting Pharmacist during the quarterly facility visits shall be resolved by the Administrator within seventy-two (72) hours.

These deficient practices could potentially affect the health, safety, and welfare of the 62 (R #s 1-62) residents listed on the census provided by the Administrator on 10/14/22, if:
1. The facility does not practice safe medication storage by not ensuring the medication room door is locked at all times, to avoid medications from potentially being in the possession of others for whom the medication was not prescribed for and could potentially be dangerous resulting in serious consequences such as, an allergic reaction, acute poisoning, overdose, medication interaction with another medication or serious side effects.
2. The facility does not inventory all discontinued medications and store them in a separate locked storage container, to help avoid medications from being in the possession of others for whom the medication was not prescribed for.
3. The facility does not maintain a daily temperature log for the designed medication refrigerator which stores the resident's medications.
4. The facility continues not to resolve the irregularities identified by the Consultant Pharmacist regarding control and storage of resident's medications.

The findings are:

A. On 10/18 /22 at 10:18 am, during observation of the facility's medication room on the first (1st) floor for the residents who are receiving Assisted Living services the following was found:

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A 034	Continued From page 43 1. The door to the medication room was wide open and there were unsecured medication blister packs and medication bottles which belonged to residents on the counters, on the shelves and in a large cardboard box. 2. There was a large cardboard box full of medication blister packs and medication bottles which had been discontinued or belonged to residents who had been discharged or passed away and there was no documentary evidence of an inventory record. 3. The resident's medications which had been discontinued or belonged to residents who had been discharged or passed away were not secured in a separate locked storage container. B. On 10/19 /22 at 12:50 pm, during observation of the facility's Memory Care Unit (MCU) medication room on the first (1st) floor the following was found: 1. There were two (2) a large cardboard boxes full of resident medications which had been discontinued or belonged to residents who had been discharged or passed away and there was no documentary evidence of an inventory record. 2. The resident's medications which had been discontinued or belonged to residents who had been discharged or passed away were not secured in a separate locked storage container. 3. The facility had no documentary evidence of a daily temperature log for the refrigerator designed for resident medications needing to be refrigerated. C. Record review of the facility's Consultant Pharmacist Quarterly Report dated 05/31/22 and 08/28/22, both reports revealed that the facility's Administrator and Director of Health Services were informed of the following continued pattern of issues:	A 034		

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A 034	Continued From page 44 1. Medications are not stored at the appropriate temperature. "Memory unit med room is warm, running about 80 degrees. Please log room temps daily and provide a plan of correction for temperature deviations, continues to be an issue." 2. "Recommend logging room temps and continue with twice daily logging for both med room, continues to be an issue." 3. Medication Rooms have discontinued medications unsecured and not logged; continues to be an issue. 4. "Recommend index sheets for narcotics; record keeping and to verify inventory coming in and out of books; memory unit has missing entries of shift change counts." 5. The facility was unable to locate the destruction logs for non-narcotics and narcotics on 08/03/22. D. On 10/19/22 at 2:58 pm, during an interview with the facility's Administrator and the Director of Health Services, they both confirmed that: 1. The 1st floor medication room: (a) The door to medication room was usually kept open while the Medication Aides are in the room, and there are numerous of resident medications which are not locked in the medication carts. (b) The resident's medications which have been discontinued are stored in a cardboard box and not in a separate locked cabinet or container. (c) There was not an inventory record for all the resident's medications which had been discontinued and were stored in the cardboard box. 2. The Memory Care Unit medication room on 1st floor: (a) The resident's medications which have been discontinued are stored in two (2) cardboard boxes and not in a separate locked cabinet or	A 034		

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A 034	Continued From page 45 container. (b) There was not an inventory record for all the resident's medications which had been discontinued and were stored in the cardboard boxes. (c) There was no daily temperature log maintained for the medication refrigerator in the MCU medication room. 3. There are continued issues from the Consultant Pharmacist's Quarterly Reports which have not been resolved by the facility.	A 034	A) The medication room was cleaned and only chemicals necessary for sanitation of surfaces has remained and these sanitation wipes are now kept in a locked cabinet when not in use. B) Chemicals will be stored according to regulations, and staff will be reeducated on storage of chemicals. C) Maintenance, RCC and Administrator will ensure SDS books are accessible to staff and that staff are educated. D) Maintenance Director will report and environmental issues related to chemical storage in monthly CQI. E) The Consulting Pharmacist was called and assisted the facility to log and destroy the medications that were observed by the surveyor stored in the Memory Care medication room. F) Health Care Coordinators were in-serviced on the Board of Pharmacy regulations regarding the proper procedure for logging medications that have been discontinued or expired and the requirement that they be placed in a locked box or cabinet while waiting for the quarterly Consulting Pharmacit visit. G) Cabinets in the medication rooms have been outfitted with locks and labeled for non-narcartic storage, and a double locking cabinet has been added in the office of the Director of Health Services for destruction with the Consulting Pharmacist quarterly.	12/16/22
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 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]	A 038		

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A 038	Continued From page 46 This REQUIREMENT is not met as evidenced by: HOUSEKEEPING SERVICES 7.8.2.38 C. Based on observation and interview, the facility failed to ensure that the facility was free from safety hazards regarding the storage of poisonous substances and hazardous chemicals from residents. These deficient practices could potentially result in the 62 (R #'s 1 - 62) residents listed on the resident census list provided by the Administrator on 10/14/22, to be at risk of harm, injury, or death if, the facility does not secure poisonous substances and hazardous chemicals from residents accessing them, which could potentially be ingested, inhaling fumes, or being exposed to chemicals spills. The findings are: A. On 10/18/22 at 10:18 am during observation of the facility's medication room on the first (1st) floor, the door was wide open, and the following was found: 1. On top of the metal cabinet anchored on the wall by the entrance door to the medication room: a 32 Fl. oz plastic spray bottle with disinfectant cleaner, a 32 Fl. oz plastic spray bottle with an unknown pink solution and a plastic container of 160 disinfecting, deodorizing, and cleaning wipes. 2. In the wall cabinet above the sink with no lock: six (6) plastic container of 160 disinfecting, deodorizing, and cleaning wipes. 3. On the counter by the sink: one (1) plastic container of 160 disinfecting, deodorizing, and	A 038		

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A 038	Continued From page 47 cleaning wipes. 4. Under the sink cabinet with no lock: a 32 Fl. oz plastic spray bottle with an unknown clear solution, a 16 Fl. oz plastic bottle of dermal wound cleanser, and a 16 Fl. oz plastic bottle of isotonic eye wash solution, 5. On top of a small counter by the entrance door to medication room: a 1-gallon plastic jug with all-purpose absorbent solution for drug disposal. B. On 10/18/22 at 10:30 am during an interview with the facility's Director of Health Services, she confirmed that the medication room door on the 1st floor was usually kept open as long as there is a "Medication Aide" in the room and the above poisonous substances and hazardous chemicals were not secured and could be accessible to the residents and no material safety data sheets were available for review for the above poisonous and hazardous chemicals.	A 038		