Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	7179	A. BUILDING: _____ B. WING _____	04/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STARLIGHT HOUSE	9109 GALAXIA WAY 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 an Initial survey completed on [redacted]/23 for the state requirements of NMAC 7.8.2, Regulations for Assisted Living Facilities for Adults. Resident Census is [redacted]	A 000	(current census is 6)	[redacted]24
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; (8) smoking policy for staff, residents and visitors; (9) methods to provide quality resident care; (10) emergency procedures;	A 017	all new employees will complete the required 16 hrs of supervised training and orientation within 10 weeks of hire date. Each employee will complete 12 hrs of training annually. All documentation and certifications will be place in employee file. House manager will monitor each employee for compliance.	

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Lori Mauch — TITLE: administrator — (X6) DATE: 3/6/24

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A 017	Continued From page 1 (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 (1-12) Based on record review and interview the facility failed to ensure that the Direct Care Staff (DCS) received 12 hours of orientation training in the topics required by regulation. This deficient practice could likely result in the [redacted] residents listed on the resident census, provided by the Owner on [redacted]23, to be at risk of harm if they are receiving care and services by DCS who have not received the required trainings. The findings are. A. Record review of DCS # 1's (hire date [redacted]22) training files revealed no documentation of completing the required 12-hours of orientation training in the following areas: 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.	A 017		

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A 017	Continued From page 2 (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. 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 (Individual Service Plan) for staff that assist with ISPs. B. On [redacted]/23 at 1:50 pm, during an interview with the Owner, she confirmed that DCS #1 did not have documentation of completing all required 12-hours of orientation training.	A 017		
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;	A 020	All new admissions will review and sign a legal admission contract with Starlight House Assisted Living. This will be completed by administrator/house manager and resident/ legal representative of resident (POA) All exsisting contracts will be updated to represent Starlight House LLC. This is presented to resident/POA/~~resident~~ for review and signature. Starlight House will follow all DOH regulations	[redacted]/24

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A 020	Continued From page 3 (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; (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	A 020		

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A 020	Continued From page 4 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 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).	A 020		

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A 020	Continued From page 5 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 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	A 020		4-10-24

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A 020	Continued From page 6 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] This REQUIREMENT is not met as evidenced by: 7.8.2.20 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	A 020		4-6-24

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A 020	Continued From page 7 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 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 [redacted] residents whose admission agreements were reviewed for compliance were updated at the time of the company's transition. This deficient	A 020		

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A 020	Continued From page 8 practice could likely result in the resident's estate/legal representative to be at risk of not receiving a refund of monies owed from the facility or being aware of potential additional charges that can occur. The findings are: A. Record review of the facility's license revealed that the change of ownership took place on [redacted]/23. B. Record review of R #2's resident file revealed no documentation that the admission agreement dated [redacted] was updated. C. On [redacted]23 at 9:20 am, during an interview with the Owner she confirmed that the admission agreement for R #2 had not been updated.	A 020		
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;	A 025	A preadmission evaluation will be performed 15 days prior to admission to determine the resident level of care required. This evaluation will include: 1. ADL's 2. Cognitive ability 3. Communication & hearing 4. Vision 5. Physical functioning. 6. Incontinence of B+B. 7. psychological well being. psychosocial well being 8. Mood + behavior 9. Activity / interests. 10. Diagnoses 11. health condition. 12 nutritional status 13. oral + dental status 14. Skin condition 15 medication use + level of assistance needed.	[redacted]/24

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A 025	Continued From page 9 (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; (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]	A 025	Continued A 025 16. Special treatments + procedures or special medical needs ie hospice 17. Safety needs / high risk behavior hx of falls, agition, wandering. fire safety issues.	

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A 025	Continued From page 10 This REQUIREMENT is not met as evidenced by: 7.8.2.25 A Based on record review and interview, the facility failed to ensure for [redacted] residents whose resident files were reviewed for compliance included Evaluations/Assessments that were updated within 15-days prior to the change of ownership on [redacted]/23. This deficient practice is likely to result in the residents not receiving appropriate care/services upon admission if the Direct Care Staff (DCS) are not aware of what the resident's needs are. The findings are: A. Record review of R #2's resident file revealed no documentation that the resident evaluation/assessment dated [redacted]/22 was updated. B. On [redacted]/23 at 9:50 am, during an interview with the Owner, she confirmed that the Evaluations/Assessments for R #2 had not been updated, when the change of ownership occurred on [redacted]/23.	A 025		
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	A 035	All care providers will be in compliance with medication pass process in accordance with State + federal law. A pharmacy provided medication Administration record will be followed by each DCS. All medications listed on the MAR will include brand + generic name and will include max doses. A written consent will be obtained by each resident or representative giving DSC permission to assist with medication administration. PRN medication will include reason for medication and MDD. Results of medication will be documented accordingly. Starlight house will provide a	

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A 035	Continued From page 11 without an order from the physician, physician assistant or nurse practitioner and with entry into the resident's record. A. State board of nursing licensed or certified health care professionals are responsible for the administration of medications. Administration may only be performed by these individuals. B. Facility staff may assist a resident with the self-administration of medications if written consent by the resident is given to the administrator of the facility or the administrator ' s designee. If the resident is incapable of giving consent, the surrogate decision maker named in accordance with New Mexico law may give written consent for assistance with self-administration of medications. All staff that assist with self-administration of medications shall have successfully completed a state approved assistance with self-administration of medication training program or be licensed or certified by the state board of nursing. C. PRN (pro re nada) medication. (1) Physician or physician extender ' s orders for PRN medications shall clearly indicate the circumstances in which they are to be used, the number of doses that may be given in a 24-hour period and indicate under what circumstances the primary care practitioner (PCP) is to be notified. (2) The utilization of PRN medications shall be reviewed routinely. Frequent or escalating use of 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	A 035	Continued A 035 current drug manual/handbook for reference. House manager will monitor this process. Residents medical information such as known allergies will be listed on each MAR, resident diagnosis, PCP, the dosage, strength, route and frequency will be listed on MAR Any refusal of medication will be documented on the MAR and resident provider will be notified. Any and all medication errors will be reported to PCP immediately and documented in resident record All unused medication, outdated, or recalled medication will be held in a locked box and destroyed by pharmacist every 3 months. during pharmacy audit. All medication will be documented on discontinued form.	[redacted]/24

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A 035	Continued From page 12 material that contains information relating to drug interactions and side effects on the premises. Staff that assist in the self-administration of medications shall know interactions or possible side effects that might occur. F. Medications prescribed for one resident shall not be used for another resident. G. Medication assistance record (MAR). For residents who are not independent and require assistance with self administration, the facility shall have a MAR that documents the details of the residents' medication, including PRN and over-the-counter medication that is assisted with self-administration by qualified staff or administered to the resident by licensed or certified staff. The information in the MAR shall include: (1) the resident's name; (2) any known allergies to medication that the resident has; (3) the name of the resident's PCP or the prescriber of the medication; (4) the diagnosis or reason for the medication; (5) the name of the medication, including the drug product brand name and the generic name; (6) notation if the medication is a schedule II-IV drug; (7) the dosage of the medication; (8) the strength of the medication; (9) the frequency or how often the medication is 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,	A 035		3-6-24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	7179	A. BUILDING: _____ B. WING _____	04/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STARLIGHT HOUSE	9109 GALAXIA WAY 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 13 respiration, blood pressure, blood sugar) as required by the medication order; (15) the date and time that the medication is self-administered, administered with assistance or is administered; (16) the initials and signature of the person assisting with or administering the medication; (17) the desired results obtained from or problems encountered with the medication (pain relieved, allergic reaction, etc.); (18) any refused dose of medication; (19) any missed dose of medication; and (20) any medication error. H. No medication shall be stopped or started without specific orders from the primary care physician. I. If a resident refuses to take a prescribed medication, it shall be documented and the facility shall report it to the prescriber. J. A suspected adverse reaction to a medication shall be documented on the MAR and reported immediately to the PCP and the resident's surrogate decision maker. If applicable, emergency medical treatment shall be arranged. Documentation of the event shall be kept in the resident's record. K. Prescription medication, other than blister packs and unit dose containers, shall be kept in the original container with a pharmacy label that includes the following: (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	A 035		

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A 035	Continued From page 14 assisted with the medication delivery. M. The facility shall report all medication errors to the physician, documentation of medication errors and the prescriber's response shall be kept in the resident's record. N. The facility shall develop and follow a written policy for unused, outdated, or recalled medications kept in the facility in accordance with 16.19.11.10 NMAC (AS AMENDED). [7.8.2.35 NMAC - Rp, 7.8.2.35 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.35 B G (5) Based on record review and interview, the facility failed to ensure that the: 1. The Direct Care Staff (DCS) who assist residents with the self-administration of medications had completed a state approved Self-Administration of Medications course and had received a certificate of completion. 2. Medications listed on the Medication Administration Record (MAR) included both the brand and generic names. This deficient practice has the potential for all [redacted] residents listed on the census provided by the Owner on [redacted]/23 to be at risk for harm/injury if: 1. Residents are not receiving their medications correctly because the DCS have not completed a state approved Self-Administration of Medications course and received a certificate of completion. 2. Medications listed on the MARS do not have both the brand/generic names and the Direct	A 035		

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A 035	Continued From page 15 Care Staff (DCS) who assist with medications do not know what the medication is for. The findings are: Findings related to medication certificates. A. Record review of DCS # 1's employee file revealed no documentation that a state approved Self-Administration of Medication course had been completed or a certificate of completion was received. B. On [redacted]/23 at 3:10 pm, during an interview with the Owner, she confirmed that there was no documentation available for review that DCS #1 had completed a state approved Self-Administration of Medication course or received a certificate of completion. Findings related to brand/generic medication names. C. Record review of R #1's MAR [redacted]/23 through [redacted]/23 (all handwritten entries) revealed that it did not include both the brand/generic names for: 1. [redacted] 2. [redacted] 3. [redacted] 4. [redacted] 5. [redacted] 6. [redacted] 7. [redacted]	A 035		

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A 035	Continued From page 16 D. Record review of R #2's MAR [redacted]/23 through [redacted]/23 (all handwritten entries) revealed that it did not include both the brand/generic names for: 1. [redacted] 2. 3. 4. 5. 6. 7. 8. 9. 10. 11. 12. E. Record review of R #3's MAR [redacted]/23 through [redacted]/23 (all handwritten entries) revealed that it did not include both the brand/generic names for: 1. [redacted] 2. 3. 4. 5. 6. 7.	A 035		

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A 035	Continued From page 17 [redacted] 8. [redacted] F. Record review of R #4's MAR [redacted]/23 through [redacted]/23 (all handwritten entries) revealed that it did not include both the brand/generic names for: 1. [redacted] 2. [redacted] 3. [redacted] 4. [redacted] 5. [redacted] 6. [redacted] 7. [redacted] 8. [redacted] 9. [redacted] 10. [redacted] 11. [redacted] 12. [redacted] 13. [redacted] G. On [redacted]/23 at 1:55 pm, during an interview with the Owner, she confirmed that the MAR for [redacted]/23 through [redacted]23 for R #s 1-4 did not include both the Brand/Generic names for the above listed medications.	A 035		
A 063	7 NMAC 8.2.63 Fire Extinguishers FIRE EXTINGUISHERS: Fire extinguisher(s) must be located in the facility, as approved by the state fire marshal or the fire prevention authority with jurisdiction.	A 063	Fire extinguishers will be located in approved location in accordance with the State Fire Marshall. All fire extinguishers will be inspected monthly + properly documented by house manager/Administrator	[redacted]/24

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A 063	Continued From page 18 A. Facilities must as a minimum have two (2) 2A10BC fire extinguishers: (1) one (1) extinguisher located in the kitchen or food preparation area; (2) one (1) extinguisher centrally located in the facility; (3) all fire extinguishers shall be inspected yearly and recharged as needed; all fire extinguishers must be tagged noting the date of the inspection; (4) the maximum distance between fire extinguishers shall be fifty (50) feet. B. Fire extinguishers, alarm systems, automatic detection equipment and other fire fighting equipment shall be properly maintained and inspected as recommended by the manufacturer, state fire marshal, or the local fire authority. [7.8.2.63 NMAC - Rp, 7.8.2.62 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.63 B Reference NAPA 10, Standard for Portable Fire Extinguishers, 1998 Edition: 4-3 Inspection. 4-3.1* Frequency. Fire extinguishers shall be inspected when initially placed in service and thereafter at approximately 30-day intervals. Fire extinguishers shall be inspected at more frequent intervals when circumstances require. Based on observation and interview, the facility failed to ensure that the fire extinguishers were being inspected monthly as recommended by the manufacturer. This deficient practice could likely result in all [redacted] residents identified on the census provided by the Owner on [redacted]/23, staff	A 063		

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A 063	Continued From page 19 members, and other building occupants to be at risk of harm, injury, or death if a fire were to occur and the fire extinguishers did not work. The findings are: A. On [redacted]/23 at 9:50 am, during observation of the two facility fire extinguishers (one in the Westside hallway and one in the laundry room), it was observed that they had not been inspected monthly as recommended by the manufacturer. B. On [redacted]23 at 10:15 am, during an interview with the Owner, she confirmed that both fire extinguishers in the facility had not been inspected monthly.	A 063		
A 065	7 NMAC 8.2.65 Fire Drills FIRE DRILLS: All facilities shall conduct monthly fire drills which are to be documented. A. There shall be at least one (1) documented fire drill per month and at a minimum, one documented fire drill each eight (8) hours (day, evening, night) per quarter that employs the use of the fire alarm system or the detector system in the facility. B. A record of the monthly fire drills shall be maintained on file in the facility and readily available. Fire drill records shall show: (1) the date of the drill; (2) the time of the drill; (3) the number of staff participating in the drill; (4) any problem noted during the drill; and (5) the evacuation time in total minutes. C. If applicable, the local fire department may be requested to supervise and participate in fire drills. [7.8.2.65 NMAC - Rp, 7.8.2.65 NMAC, 01/15/2010]	A 065	Fire drills will be perfprmed mpnthly and prpperly dpcumented. A recprd will be maintained pn file in the facility and will be readily available uppn request. Fire drill recprds will include: date, time, number pf staff participating in the drill. Any issues pr prpblems pccuring during the drill will be dpcumented alpng with evacuatipn time in in tptal minutes.	[redacted]/24

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A 065	Continued From page 20 This REQUIREMENT is not met as evidenced by: 7.8.2.65 A Based on record review and interview, the facility failed to ensure that fire drills were conducted at least monthly. This deficient practice could likely result in the [redacted] residents identified on the census list, provided by the Owner on [redacted]23, to be at risk of harm, injury, or death if Direct Care Staff (DCS) do not know how to safely evacuate the residents from the building if a fire were to occur. The findings are: A. On [redacted]/23 at 10:20 am, record review of the facility's fire drill records dated [redacted]22 through [redacted]/23 revealed that there was no documentation showing that the facility conducted any monthly fire drills since [redacted]/23. B. On [redacted]/23 at 10:35 am, during an interview with the Owner, she confirmed that the facility had not conducted any monthly fire drills since [redacted]23.	A 065		
A 066	7 NMAC 8.2.66 Staff and Resident Fire and Safety Training STAFF AND RESIDENT FIRE AND SAFETY TRAINING: A. All staff of the facility shall know the location and the proper use of fire extinguishers and the other procedures to be followed in case of fire or other emergencies. The facility should request the local fire prevention authority to give periodic instructions in the use of fire prevention and	A 066	Staff, residents + family members will be oriented to location + use of fire extinguishers. Family + residents will recieve fire safety orientation within 2 wks of admission + documented in residents file	

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A 066	Continued From page 21 techniques of evacuation. B. Facility staff shall be instructed as part of their duties to constantly strive to detect and eliminate potential safety hazards, such as loose handrails, frayed electrical cords, blocked exits or exit-ways and any other condition which could cause burns, falls, or other personal injury to the residents or staff. C. Each new resident admitted to the facility shall be given an orientation tour of the facility to include the location of the exits, fire extinguishers and telephones and shall be instructed in the actions to be taken in case of fire or other emergencies. D. Fire drill procedures. The facility must conduct at least one (1) fire drill each month. (1) Fire drills shall be held at different times of the day, evening and night. (2) The fire alarm system or detector system in the facility shall be used in the fire drills. During the night, the fire drill alarm may be silenced. (3) During the fire drills, emphasis shall be placed upon orderly evacuation under proper discipline rather than upon speed. (4) A record of the conducted fire drills shall be maintained on file in the facility. The record shall show the date and time of the drill, the number of personnel participating in the drill, any problem(s) noted during the drill and the evacuation time in total minutes. (5) The local fire department may be requested to supervise and participate in the fire drills. [7.8.2.66 NMAC - Rp, 7.8.2.63 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.66 C	A 066	monthly inspections will be performed monthly + repaired as needed.	3-6-24

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A 066	Continued From page 22 Based on record review and interview, the facility failed to ensure that Residents/Family Members received fire safety and evacuation orientation upon admission (Change of Ownership) to the facility. This deficient practice could likely result in all [redacted] residents listed on the census provided by the Owner on [redacted]/23, to be at risk of harm, injury, or death if a fire or other emergency were to occur because residents/family members do not know where the fire safety equipment is, the evacuation route, and/or where the exits are. The findings are: A. Record review of the facility's license revealed that the change of ownership took place on [redacted]/23. B. Record review of R #1's (Date of Admission [redacted] resident file, revealed no documentation that they or their families received Fire Safety and Evacuation orientation before or since the change of ownership. C. Record review of R #2's (Date of Admission [redacted] resident file, revealed no documentation that they or their families received Fire Safety and Evacuation orientation before or since the change of ownership. D. Record review of R #3's (Date of Admission [redacted] resident file, revealed no documentation that they or their families received Fire Safety and Evacuation orientation before or since the change of ownership. E. Record review of R #4's (Date of Admission [redacted] resident file, revealed no documentation that they or their families received Fire Safety and Evacuation orientation before or	A 066		

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A 068	Continued From page 26 (2) The assisted living facility shall hold a team meeting prior to accepting or retaining a hospice resident in accordance with " Exceptions to admission, readmission and retention, " Subsection C of 7.8.2.20 NMAC. (3) Upon admission of a resident into hospice care, the assisted living facility shall designate a section of the resident ' s record for hospice documentation. (a) The facility shall provide individual records for each resident. (b) The hospice agency shall leave documentation at the facility in the designated section of the resident ' s record. (4) The assisted living facility shall provide the resident and family or surrogate decision maker with information on palliative care and shall support the resident ' s freedom of choice with regard to decisions. (5) Hospice services shall be available twenty-four (24) hours a day, seven (7) days a week for hospice residents, families and facility staff and may include continuous nursing care for hospice residents as needed. These services shall be delivered in accordance with the resident ' s individual service plan (ISP) and pursuant to 7.8.2 26 NMAC. (6) The assisted living facility shall ensure the coordination of services with the hospice agency. (a) The resident's individual service plan (ISP) shall be updated with significant changes in the resident ' s condition and care needs. (b) The assisted living facility shall receive information and communication from the hospice staff at each visit. (i) The information shall include the resident status and any changes in the ISP (i.e., medication changes, etc.). (ii) The information shall be in the form of a	A 068		

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A 066	Continued From page 23 since the change of ownership. F. On [redacted]23 at 10:30 am, during an interview with the Owner, she confirmed that there was no documentation that R #s 1-4 received Fire Safety and Evacuation orientation upon admission.	A 066		
A 068	7 NMAC 8.2.68 Hospice HOSPICE: An assisted living facility that provides or coordinates hospice care and services shall meet the requirements in this section, in addition to the rules applicable to all assisted living facilities, 7.8.2 NMAC. A. Definitions: in addition to the requirements for all assisted living facilities pursuant to " DEFINITIONS, " 7.8.2.7 NMAC, the following definitions shall also apply. (1) " Hospice agency " means an organization, company, for-profit or non-profit corporation or any other entity which provides a coordinated program of palliative and supportive services for physical, psychological, social and the option of spiritual care of terminally ill people and their families. The services are provided by a medically directed interdisciplinary team in the person's home and the agency is required to be licensed pursuant to 7.12 NMAC. (2) " Hospice care " means a focus on palliative, rather than curative care. The goal of the plan of care is to help the patient live as comfortably as possible, with emphasis on eliminating or decreasing pain and other uncomfortable symptoms. (3) " Licensed assisted living provider " means a facility that provides twenty-four (24) hour assisted living and is licensed by the department of health. (4) " Hospice services " means a program of	A 068	Each admission into starlight house that is contracted with a hospice agency will have an ISP provided by the hospice agency within one week of admission. Each staff will recieve 6 hrs of hospice training to include 1 hr of training specific to residents ISP. The hospice nurse will sign off at the completion of training for each staff. This will be monitored by the house manager & will be completed within 2 wks of admission.	[redacted]/24

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A 068	Continued From page 24 palliative and supportive services which provides physical, psychological, social and spiritual care for terminally ill patients and their family members. (5) " Care coordination requirements " means a written document that outlines the care and services to be provided by the hospice agency for assisted living residents that require hospice services. (6) " Palliative care " means a form of medical care or treatment that is intended to reduce the severity of disease symptoms, rather than to reverse progression of the disease itself or provide a cure. (7) " Terminally ill " means a diagnosis by a physician for a patient with a prognosis of six (6) months or less to live. (8) " Visit notes " means the documentation of the services provided for hospice residents and includes ongoing care coordination. B. Employee training and support. A facility that provides hospice services shall provide the following education and training for employees who assist with providing these services: (1) provide a minimum of six (6) hours per year of palliative/hospice care training, which includes one (1) hour specific to the hospice resident ' s ISP, in addition to the basic staff education requirements pursuant to 7.8.2.17 NMAC; and (2) offer an ongoing employee psychological support program for end of life care issues. C. Individual service plan (ISP) requirements. (1) Each resident who receives hospice services shall be provided the necessary palliative care to meet the individual resident ' s needs as outlined in the ISP and shall include one (1) hour of training specific to the resident for all direct care staff. (2) The assisted living facility, in coordination with	A 068		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	7179	A. BUILDING: _____ B. WING _____	04/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STARLIGHT HOUSE	9109 GALAXIA WAY 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 068	Continued From page 25 the hospice provider, shall create an ISP that identifies how the resident's needs are met and includes the following: (a) the requirements set forth in the " Individual Service Plan, " 7.8.2.26 NMAC, and " Exceptions to admission, readmission and retention, " Subsection C of 7.8.2.20 NMAC; (b) what services are to be provided; (c) who will provide the services; (d) how the services will be provided; (e) a delineation of the role(s) of the hospice provider and the assisted living facility in the ISP process; (f) documentation (visit notes) of the care and services that are provided with the signature of the person who provided the care and services; and (g) a list of the current medications or biologicals that the resident receives and who is authorized to administer them. (3) Medications shall be self-administered, self-administered with assistance by an individual that has completed a state approved program in medication assistance or administered by the following individuals: (a) a physician; (b) a physician extender (PA or NP); (c) a licensed nurse (RN or LPN); (d) the resident if their PCP has approved it; (e) family or family designee; and (f) any other individual in accordance with applicable state and local laws. D. Care coordination. (1) The assisted living facility shall be knowledgeable with regard to the hospice requirements pursuant to 7.12 NMAC and ensure that the hospice agency is well informed with regard to the assisted living provisions pursuant to Subsection C of 7.8.2.20 NMAC.	A 068		

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A 068	Continued From page 27 verbal report to the assisted living facility staff and also in the form of written documentation. (c) The assisted living facility or the family/resident shall reserve the right to schedule care conferences as the needs of the resident and family dictate. The care conferences shall include all care team members. (d) Concerns that arise with regard to the delivery of services from either the assisted living facility or the hospice agency shall first be addressed with the facility administrator and the hospice agency administrator. (i) The process may be informal or formal depending on the nature of the issue. (ii) If an issue can not be resolved or if there is an immediate danger to the resident the appropriate authority shall be notified. E. Additional provisions. An assisted living facility that provides or coordinates hospice care and services shall make additional provisions for the following requirements: (1) individual services and care: each resident receiving hospice services shall be provided the necessary palliative procedures to meet individual needs as defined in the ISP; (2) private visiting space: (a) physical space for private family visits; (b) accommodations for family members to remain with the patient throughout the night; and (c) accommodations for family privacy after a resident ' s death. F. Medicare and medicaid restrictions. Assisted living facilities shall not accept a resident considered " hospice general inpatient " which would be billable to medicare or medicaid because the facility will not qualify for payment by medicare or medicaid. [7.8.2.68 NMAC - N, 01/15/2010]	A 068		

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A 068	Continued From page 28 This REQUIREMENT is not met as evidenced by: 7.8.2.68 B(1)D(2) Based on record review and interview, the facility failed to ensure that: 1. Direct Care Staff (DCS) had received the required six (6) hours of palliative/hospice training including one hour specific to resident's Individual Service Plan (ISP) annually when the facility is providing care and services for hospice residents. 2. Provide documentation that a team meeting was held before residents are placed on hospice. These deficient practices could likely result in the [redacted] residents receiving Hospice services to be at risk of harm or injury if: 1. The DCS do not know the proper methods for providing care and services for hospice residents. 2. A team meeting was not convened prior admitting, readmitting, or retaining residents on hospice to ensure the facility could meet the higher level of care the resident may need. Findings related to DCS training: A. Record review of the House Manager's (DCS #2) (hire date [redacted]/22) training file, revealed no documentation of completing 6-hours of palliative/hospice training to include one hour specific to resident's Individual Service Plan (ISP). B. On [redacted]23 at 2:05 pm, during an interview with the Owner, she confirmed that the House Manager (DCS #2) has no documentation of completing 6-hours of palliative/hospice training to include one hour specific to resident's Individual Service Plan (ISP).	A 068	Tpe text here	

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A 068	Continued From page 29 Findings regarding Hospice/Facility/Family Meeting: C. Record review of R[redacted] resident file revealed no documentation of a team meeting prior to accepting or retaining a hospice resident in accordance with "Exceptions to admission, readmission and retention," Subsection C of 7.8.2.20 NMAC. D. Record review of R[redacted] resident file revealed no documentation of a team meeting prior to accepting or retaining a hospice resident in accordance with "Exceptions to admission, readmission and retention," Subsection C of 7.8.2.20 NMAC. E. Record review of R[redacted] resident file revealed no documentation of a team meeting prior to accepting or retaining a hospice resident in accordance with "Exceptions to admission, readmission and retention," Subsection C of 7.8.2.20 NMAC. F. On [redacted]23 at 10:45 am, during an interview with the Owner, she confirmed that documentation of a hospice team meeting was not in the files of R #s [redacted]	A 068	TyAApe text here	