Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	4107	A. BUILDING: _____ B. WING _____	C 11/23/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORNINGSTAR ASSISTED LIVING AND MEMORY CAI	2041 S PACHECO ST SANTA FE, NM 87505

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A 000	Initial Comments The following deficiencies were cited during a Complaint survey completed on 11/23/22, in accordance with the state requirements pursuant to the 7.8.2 NMAC Regulations for Assisted Living Facilities for Adults. Complaint Intake ID #NM00054322 was unsubstantiated with deficiencies cited. Complaint Intake ID #NM00056242 was unsubstantiated with no deficiencies cited. Complaint Intake ID #NM00056295 was unsubstantiated with no deficiencies cited. Complaint Intake ID #NM00056597 was substantiated with deficiencies cited. Complaint Intake ID #NM00057062 was unsubstantiated with deficiencies cited. Complaint Intake ID #NM00059265 was substantiated with deficiencies cited. Complaint Intake ID #NM00061499 was unsubstantiated 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. Care Mangers: CM 7. Medication Care Manager: MCM 8. Medication Technicians: Med. Tech. 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	A 000	Responses to the cited deficiencies do not constitute an admission or agreement by the community to the truth of the facts alleged or conclusion set forth in the statement of deficiencies. The plan of correction is prepared solely as a matter of compliance with federal and state law	

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A 000	Continued From page 1 18. Policy and Procedure: P/P 19. Emergency Medical Services: EMS 20. Emergency Room: ER 21. milligrams: mg 22. New Mexico Administrative Code: NMAC 23. New Mexico Department of Health - Division of Health Improvement: NM DOH - DHI	A 000		
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; (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	A 021	A-021 Resident Records A. With respect to HOW the facility will CORRECT the problem identified in the deficiency list: 1. Resident #4 no longer resides in the community. B. With respect to what the facility will do to PREVENT the same deficiency from recurring: 1. Regional VP of Wellness (RVPW) or designee will in-service community leadership on coordination of care and documentation requirements for Home Health and Hospice providers. Training will take place on or before December 31st 2022 and documented on an in-service sign-in sheet. 2. ED or designee will educate all ancillary service providers for both home health and hospice services on the coordination of care and documentation requirements in accordance with NMDOH regulations, MorningStar policy and third-party agreement. These meetings will be completed on or before January 15th, 2023 and documented on in-service sign-in sheet. 3. WD or designee will meet with any home health or hospice agency servicing the community at least monthly for coordination of care meetings and to ensure appropriate and adequate documentation by the agency are complete. These meetings will be documented in the applicable resident's charts under "Coordination of Care"	

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A 021	Continued From page 2 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, 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	A 021	A-021 Resident Records A. With respect to HOW the facility will CORRECT the problem identified in the deficiency list: 1. Resident #4 no longer resides in the community. B. With respect to what the facility will do to PREVENT the same deficiency from recurring: 1. Regional VP of Wellness (RVPW) or designee will in-service community leadership on coordination of care and documentation requirements for Home Health and Hospice providers. Training will take place on or before December 31st 2022 and documented on an in-service sign-in sheet. 2. ED or designee will educate all ancillary service providers for both home health and hospice services on the coordination of care and documentation requirements in accordance with NMDOH regulations, MorningStar policy and third-party agreement. These meetings will be completed on or before January 15th, 2023 and documented on in-service sign-in sheet. 3. WD or designee will meet with any home health or hospice agency servicing the community at least monthly for coordination of care meetings and to ensure appropriate and adequate documentation by the agency are complete. These meetings will be documented in the applicable resident's charts under "Coordination of Care"	

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A 021	Continued From page 3 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 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]	A 021	A-021 Resident Records A. With respect to HOW the facility will CORRECT the problem identified in the deficiency list: 1. Resident #4 no longer resides in the community. B. With respect to what the facility will do to PREVENT the same deficiency from recurring: 1. Regional VP of Wellness (RVPW) or designee will in-service community leadership on coordination of care and documentation requirements for Home Health and Hospice providers. Training will take place on or before December 31st 2022 and documented on an in-service sign-in sheet. 2. ED or designee will educate all ancillary service providers for both home health and hospice services on the coordination of care and documentation requirements in accordance with NMDOH regulations, MorningStar policy and third-party agreement. These meetings will be completed on or before January 15th, 2023 and documented on in-service sign-in sheet. 3. WD or designee will meet with any home health or hospice agency servicing the community at least monthly for coordination of care meetings and to ensure appropriate and adequate documentation by the agency are complete. These meetings will be documented in the applicable resident's charts under "Coordination of Care"	

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A 021	Continued From page 4 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 4) of 7 (R #s 1-7) 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. Record review of R #4's facility record revealed [redacted] was admitted on [redacted]21, and there was no documentary evidence of progress notes completed by the: 1. Home Health agency which was ordered on 12/22/21. 2. Hospice agency which was ordered on 03/11/22. B. On 11/16/22 at 4:06 pm, during an interview with the facility's Resident Care Coordinator, she confirmed that R #4's facility record did not have any progress notes completed by the Home Health or Hospice agencies for the health services which were provided.	A 021	A-021 Resident Records A. With respect to HOW the facility will CORRECT the problem identified in the deficiency list: 1. Resident #4 no longer resides in the community. B. With respect to what the facility will do to PREVENT the same deficiency from recurring: 1. Regional VP of Wellness (RVPW) or designee will in-service community leadership on coordination of care and documentation requirements for Home Health and Hospice providers. Training will take place on or before December 31st 2022 and documented on an in-service sign-in sheet. 2. ED or designee will educate all ancillary service providers for both home health and hospice services on the coordination of care and documentation requirements in accordance with NMDOH regulations, MorningStar policy and third-party agreement. These meetings will be completed on or before January 15th, 2023 and documented on in-service sign-in sheet. 3. WD or designee will meet with any home health or hospice agency servicing the community at least monthly for coordination of care meetings and to ensure appropriate and adequate documentation by the agency are complete These meetings will be documented in the applicable resident's charts under "Coordination of Care"	

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A 025	Continued From page 5	A 025		
A 025	7 NMAC 8.2.25 Resident Evaluation RESIDENT EVALUATION: A. A resident evaluation shall be completed by an appropriate staff member within fifteen (15) days prior to admission to determine the level of assistance that is needed and if the level of services required by the resident can be met by the facility. B. The initial resident evaluation shall establish a baseline in the resident ' s functional status and thereafter assist with identifying resident changes. The resident evaluation shall be reviewed and updated at a minimum of every six (6) months or when there is a significant change in the resident ' s health status. C. The resident ' s evaluation shall be documented on a resident evaluation form and at a minimum include the following abilities, behaviors or status: (1) activities of daily living; (2) cognitive abilities; reasoning and perception; the ability to articulate thoughts, memory function or impairment, etc; (3) communication and hearing; ability to communicate needs and understand instructions, etc; (4) vision; (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	A 025	A025-Resident Evaluation A. With respect to HOW the facility will CORRECT the problem identified in the deficiency list: 1. Resident #'s 1, 2 and 4 no longer reside in the community. B. With respect to what the facility will do to PREVENT the same deficiency from recurring: 1. ED or designee will educate care coordinators and nurses on the requirement to have a move-in evaluation completed at least 15 days prior to admission and an H&P (history and physical completed within 6 months. Training will be completed on or before December 31st, 2022 and documented on an in-service sign-in sheet. 2. All new move-ins will be reviewed at the community's monthly QA meeting to ensure compliance with the pre-admission assessment requirement, nurse or nurse practitioner review/sign-off and track H&P requirements. These reviews will be documented on a QA review tool.	

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A 025	Continued From page 6 needed with medications; (16) special treatments and procedures or special medical needs such as hospice; and (17) safety needs/high risk behaviors; history of falls agitation, wandering, fire safety issues, etc. D. The resident evaluation shall include a history and physical examination and an evaluation report by a physician or a physician extender within six (6) months of admission. A resident shall have a medical evaluation by a physician or a physician extender at least annually. E. The resident evaluation shall be reviewed and if needed revised by a licensed practical nurse, registered nurse or physician extender at the time the individual service plan is reviewed, at a minimum of every six (6) months or when a significant change in health status occurs. [7.8.2.25 NMAC - Rp, 7.8.2.25 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.25 D. E. Based on record review and interview, the facility failed to ensure for 3 (R #s 1, 2 and 4) of 7 (R #s 1-7) 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 resident had a History and Physical (H&P) completed by a physician or a physician extender within six (6) months of admission. 3. The resident's Evaluations were reviewed and if needed revised by a Licensed Practical Nurse (LPN), Registered Nurse (RN), or a Physician	A 025	A025-Resident Evaluation A. With respect to HOW the facility will CORRECT the problem identified in the deficiency list: 1. Resident #'s 1, 2 and 4 no longer reside in the community. B. With respect to what the facility will do to PREVENT the same deficiency from recurring: 1. ED or designee will educate care coordinators and nurses on the requirement to have a move-in evaluation completed at least 15 days prior to admission and an H&P (history and physical completed within 6 months. Training will be completed on or before December 31st, 2022 and documented on an in-service sign-in sheet. 2. All new move-ins will be reviewed at the community's monthly QA meeting to ensure compliance with the pre-admission assessment requirement, nurse or nurse practitioner review/sign-off and track H&P requirements. These reviews will be documented on a QA review tool.	

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A 025	Continued From page 7 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 H&P 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 Care Mangers and the Medication Care Managers are knowledgeable and providing the resident with the level of assistance that is required according to the evaluation. The findings are: The findings for R #1 are: A. Record review of R #1's facility record revealed that R #1's admission date was on [redacted]20, and the following was identified: 1. There was no documentary evidence that a H&P was done within 6 months of admission. 2. The initial Move-in Evaluation was done on [redacted]22, which was not completed within 15 days prior to admission.	A 025		

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A 025	Continued From page 8 B. On 11/21/22 at 1:51 pm, during an interview with the Resident Care Coordinator, she confirmed the above findings for the R #1 listed above. The findings for R #2 are: C. Record review of R #2's facility record revealed that R #2's admission date was on [redacted]/22, and the following was identified: 1. There was no documentary evidence that a H&P was done within 6 months of admission. 2. There was no documentary evidence that the Evaluation dated 06/23/22, was reviewed by a LPN, RN, or a Physician Extender. D. On 11/21/22 at 1:51 pm, during an interview with the Resident Care Coordinator, she confirmed the above findings for the R #2 listed above. The findings for R #4 are: E. Record review of R #4's facility record revealed that R #4's admission date was on [redacted]21, and the following was identified: 1. There was no documentary evidence that a H&P was done within 6 months of admission. 2. The following Evaluations dated 08/05/21 and 08/07/21, had no documentary evidence that the Evaluations were reviewed by a LPN, RN, or a Physician Extender. F. On 11/16/22 at 4:06 pm, during an interview with the facility's Resident Care Coordinator, she confirmed the above findings for the R #4 listed above.	A 025	A025-Resident Evaluation A. With respect to HOW the facility will CORRECT the problem identified in the deficiency list: 1. Resident #'s 1, 2 and 4 no longer reside in the community. B. With respect to what the facility will do to PREVENT the same deficiency from recurring: 1. ED or designee will educate care coordinators and nurses on the requirement to have a move-in evaluation completed at least 15 days prior to admission and an H&P (history and physical completed within 6 months. Training will be completed on or before December 31st, 2022 and documented on an in-service sign-in sheet. 2. All new move-ins will be reviewed at the community's monthly QA meeting to ensure compliance with the pre-admission assessment requirement, nurse or nurse practitioner review/sign-off and track H&P requirements. These reviews will be documented on a QA review tool.	

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A 026	Continued From page 9 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 026	A026-Individualized Service Plans A. With respect to HOW the facility will CORRECT the problem identified in the deficiency list: 1. Resident's #'s 2 and 4 no longer reside in the community. B. With respect to what the facility will do to PREVENT the same deficiency from recurring: 1. ED or designee will conduct audit of all current residents' most recent ISP to ensure review/sign-off my licensed or registered nurse. Audit will be conducted using an internal audit tool and completed on or before January 15th, 2023 2. ED or designee will educate coordinators on the requirement to have ISPs reviewed by a licensed or registered nurse. This training will take place on or before December 31st, 2022 and documented on an in-service sign-in sheet.	

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A 026	Continued From page 10 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 2 (R #s 2 and 4) of 7 (R #s 1-7) residents whose facility records were reviewed for compliance that the Individual Service Plans (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 resident's ISPs are not reviewed by a 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 are: The findings for R #2 are: A. Record review of R #2's facility record revealed that the [redacted] dated [redacted]/22, had no documentary evidence that the [redacted] was reviewed and if needed revised by a LPN, RN, or a Physician	A 026	A026-Individualized Service Plans A. With respect to HOW the facility will CORRECT the problem identified in the deficiency list: 1. Resident's #'s 2 and 4 no longer reside in the community. B. With respect to what the facility will do to PREVENT the same deficiency from recurring: 1. ED or designee will conduct audit of all current residents' most recent ISP to ensure review/sign-off my licensed or registered nurse. Audit will be conducted using an internal audit tool and completed on or before January 15th, 2023 2. ED or designee will educate coordinators on the requirement to have ISPs reviewed by a licensed or registered nurse. This training will take place on or before December 31st, 2022 and documented on an in-service sign-in sheet.	

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	4107	A. BUILDING: _____ B. WING _____	C 11/23/2022

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A 026	Continued From page 11 Extender. B. On 11/21/22 at 1:51 pm, during an interview with the Resident Care Coordinator, she confirmed the above finding for R #2. The findings for R #4 are: C. Record review of R #4's facility record revealed that the [redacted] dated [redacted]/21, had no documentary evidence that the ISP was reviewed and if needed revised by a LPN, RN, or a Physician Extender. D. On 11/16/22 at 4:06 pm, during an interview with the facility's Resident Care Coordinator, she confirmed the above finding for R #4.	A 026	A026-Individualized Service Plans A. With respect to HOW the facility will CORRECT the problem identified in the deficiency list: 1. Resident's #'s 2 and 4 no longer reside in the community. B. With respect to what the facility will do to PREVENT the same deficiency from recurring: 1. ED or designee will conduct audit of all current residents' most recent ISP to ensure review/sign-off my licensed or registered nurse. Audit will be conducted using an internal audit tool and completed on or before January 15th, 2023 2. ED or designee will educate coordinators on the requirement to have ISPs reviewed by a licensed or registered nurse. This training will take place on or before December 31st, 2022 and documented on an in-service sign-in sheet.	
A 032	7 NMAC 8.2.32 Reporting of Incidents REPORTING OF INCIDENTS: A. The facility shall insure that all suspected cases or known incidents of resident abuse, neglect or exploitation are reported in accordance with 7.1.13 NMAC. (1) The facility shall also report any incident or unusual occurrence which has or could threaten the health, safety, or welfare of the residents and staff to the licensing authority complaint hotline within twenty-four (24) hours or by the next business day, if it is a weekend or a holiday. (2) The facility shall not delay a report to the complaint hotline while an internal investigation is conducted. B. The facility is responsible for conducting and documenting the investigation of all incidents within five (5) business days and shall submit a	A 032	A032-Incident Reporting A. With respect to HOW the facility will CORRECT the problem identified in the deficiency list: 1. Executive Director (ED) or designee will review all incident reports dating back 60 days and ensure all reportable incidents have been reported to the NMDOH in accordance with occurrence reporting guidelines. This audit will be completed on or before January 15th, 2023. ED or designee will review and monitor incidents each workday, and ensure the 5 day report is submitted on time. B. With respect to what the facility will do to PREVENT the same deficiency from recurring: 1. ED and WD will all be in-serviced on reporting requirements and procedures in accordance with NMDOH regulations. In-service will take place on or before January 15th, 2023 and documented on an in-service sign-in sheet.	

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A 032	Continued From page 12 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 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	A 032	A032-Incident Reporting A. With respect to HOW the facility will CORRECT the problem identified in the deficiency list: 1. Executive Director (ED) or designee will review all incident reports dating back 60 days and ensure all reportable incidents have been reported to the NMDOH in accordance with occurrence reporting guidelines. This audit will be completed on or before January 15th, 2023. ED or designee will review and monitor incidents each workday, and ensure the 5 day report is submitted on time. B. With respect to what the facility will do to PREVENT the same deficiency from recurring: 1. ED and WD will all be in-serviced on reporting requirements and procedures in accordance with NMDOH regulations. In-service will take place on or before January 15th, 2023 and documented on an in-service sign-in sheet.	

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A 032	Continued From page 13 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] Based on record review and interview, the facility failed to ensure for 3 (R #'s 2, 3 and 4) of 7 (R #s 1-7) residents whose 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.	A 032	A032-Incident Reporting A. With respect to HOW the facility will CORRECT the problem identified in the deficiency list: 1. Executive Director (ED) or designee will review all incident reports dating back 60 days and ensure all reportable incidents have been reported to the NMDOH in accordance with occurrence reporting guidelines. This audit will be completed on or before January 15th, 2023. ED or designee will review and monitor incidents each workday, and ensure the 5 day report is submitted on time. B. With respect to what the facility will do to PREVENT the same deficiency from recurring: 1. ED and WD will all be in-serviced on reporting requirements and procedures in accordance with NMDOH regulations. In-service will take place on or before January 15th, 2023 and documented on an in-service sign-in sheet.	

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A 032	Continued From page 14 These deficient practices could potentially result in the 50 (R #s 1-50) residents listed on the census provided by the facility's Resident Care Coordinator on 11/14/22, 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 and complete an investigation to include a narrative description of the incident, the result of the facility's investigation, and plans for further actions in response to the incident. The findings are: The findings for R #2 are: A. Record review of the facility's IRs for R #2 revealed: 1. According to the facility's Internal IR dated 08/23/22, R #2: a. Was seen by the hospice aid with a cord wrapped around his neck 3 times while sitting on a chair in the hallway of the Memory Care unit. b. Was found with a red neck, bruises, and no open wounds. c. Was sent out to the ER for an evaluation. B. Record request for the facility's external incident report to the Licensing Authority and 5-day follow-up report revealed no internal investigation or follow-up report had been completed. C. On 11/16/22 at 9:43 am, during an interview with the Resident Care Coordinator, she confirmed that the facility did not report the incident involving R #2 on 08/23/22 to the Licensing Authority within 24 hours, or the next business day and the facility did not conduct an investigation and submit the follow-up report to	A 032	A032-Incident Reporting A. With respect to HOW the facility will CORRECT the problem identified in the deficiency list: 1. Executive Director (ED) or designee will review all incident reports dating back 60 days and ensure all reportable incidents have been reported to the NMDOH in accordance with occurrence reporting guidelines. This audit will be completed on or before January 15th, 2023. ED or designee will review and monitor incidents each workday, and ensure the 5 day report is submitted on time. B. With respect to what the facility will do to PREVENT the same deficiency from recurring: 1. ED and WD will all be in-serviced on reporting requirements and procedures in accordance with NMDOH regulations. In-service will take place on or before January 15th, 2023 and documented on an in-service sign-in sheet.	

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A 032	Continued From page 15 the Licensing authority within 5 business days. The findings for R #3 are: D. Record review of the facility's internal incident report received by the Licensing Authority on 05/26/22 revealed: On 05/25/22 at 03:54 am, R #3 was found on the floor during a safety round check. [redacted] The last thing [redacted] remembered was sitting on the chair and then was on the floor. R #3 was transported to the Emergency Room for evaluation. E. Record review of Emergency Room medical records revealed that the resident was admitted to the Emergency Room on [redacted]/22 for evaluation and discharged on [redacted]22 with no major injuries. F. Record review of the Fall Risk Evaluation dated 05/25/22, revealed that the evaluation was triggered due to R #3's unwitnessed fall and R #3 was categorized as a High Risk for Falling. G. Record review of the facility's Internal IRs for R #3 revealed no documentation that an internal investigation was completed and submitted to the Licensing Authority within 5 business days for the incident on 05/25/22. H. On 11/16/22 at 9:38 am, during an interview with the Resident Care Coordinator, she confirmed that there was no documentation that an internal investigation was completed for R #3's incident on 05/25/22 and submitted to the Licensing Authority within 5 business days. The findings for R #4 are:	A 032	A032-Incident Reporting A. With respect to HOW the facility will CORRECT the problem identified in the deficiency list: 1. Executive Director (ED) or designee will review all incident reports dating back 60 days and ensure all reportable incidents have been reported to the NMDOH in accordance with occurrence reporting guidelines. This audit will be completed on or before January 15th, 2023. ED or designee will review and monitor incidents each workday, and ensure the 5 day report is submitted on time. B. With respect to what the facility will do to PREVENT the same deficiency from recurring: 1. ED and WD will all be in-serviced on reporting requirements and procedures in accordance with NMDOH regulations. In-service will take place on or before January 15th, 2023 and documented on an in-service sign-in sheet.	

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A 032	Continued From page 16 I. Record review of the facility's Internal IRs for R #4 revealed: 1. According to the facility's Internal IR dated 08/16/21, R #4 reported [redacted] when [redacted] was coming out of the bathroom when [redacted] hit the corner of the wall. The Direct Care Staff (DCS) noted that R #4 had a smal [redacted] on [redacted] and gave R #4 a band-Aid to apply to the [redacted] 2. According to the facility's Internal IR dated 11/12/21, R #4 was found by one (1) of the facility's DCS in [redacted] sitting on the floor in the kitchen area. The DCS checked R #4 for any visible injuries and found a "small open cut on the back of the residents head was bleeding but not a lot". The DCS asked R #4 if she was hurting anywhere, and R #4 replied "No". The DCS called the facility nurse to come check on R #4 and while waiting for the facility nurse the DCS called 911. The DCS and the facility nurse picked up R #4 from the floor into a chair. R #4 reported to the facility nurse that "she might have gotten dizzy" and fell and hit the back of [redacted] on the counter, and [redacted] denied loss of consciousness. R #4 was transported to a local emergency room (ER) for further evaluation. 3. According to the facility's Internal IR dated 12/05/21, R #4 was found by 1 of the facility's DCS in [redacted] room [redacted] The DCS assisted R #4 off the floor and her vital signs and noticed R #4 had a [redacted] R #4 reported [redacted] was on [redacted] way to the bathroom when [redacted] fell and "was using [redacted] walker at the time of the incident." 4. According to the facility's Internal IR dated 12/19/21 at approximately 3:12 pm, R #4 complained of [redacted] R #4's daughter came to visit and requested the facility	A 032	A032-Incident Reporting A. With respect to HOW the facility will CORRECT the problem identified in the deficiency list: 1. Executive Director (ED) or designee will review all incident reports dating back 60 days and ensure all reportable incidents have been reported to the NMDOH in accordance with occurrence reporting guidelines. This audit will be completed on or before January 15th, 2023. ED or designee will review and monitor incidents each workday, and ensure the 5 day report is submitted on time. B. With respect to what the facility will do to PREVENT the same deficiency from recurring: 1. ED and WD will all be in-serviced on reporting requirements and procedures in accordance with NMDOH regulations. In-service will take place on or before January 15th, 2023 and documented on an in-service sign-in sheet.	

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A 032	Continued From page 17 staff to call 911 and send her to the ER to be evaluated. R #4 reported to the facility staff that [redacted] The Internal IR indicates that the facility staff noticed R #4 "was very confused today and threw up this morning." The facility's Wellness Director did an Event Investigation on 12.22.21, and indicated that R #4 has "Multiple falls, not using walker" and R #4's family hired a personal sitter for nights. 5. According to the facility's Internal IR dated 01/10/22, R #4 was found by 1 of the facility's DCS in [redacted] room sitting on the floor. Two of the facility's DCS assisted R #4 up into a wheelchair and asked R #4 what had occurred, R #4 did not know, [redacted] was very confused and did not know where [redacted] was. The DCS noticed R #4 had a [redacted] and when R #4 started walking [redacted] complained of [redacted] According to the Event Investigation done by the Wellness Director on 01/13/22, R #4 was assisting [redacted] who also lives at the facility in the same room. This Event Investigation indicates that R #4 will be relocating from the Assisted Living area to the Memory Care Unit called "Reflections" due to poor safety awareness and self-transfers without assistance. 6. According to the facility's Internal IR dated 01/19/22 at approximately 6:30 am, R #4 was found by 1 of the facility's DCS in [redacted] room on the floor and noticed a "cut on the back side of [redacted] with some bleeding. The DCS took R #4's vital signs and called the facility's nurse. R #4 reported that [redacted] was going to the bathroom when [redacted] The Internal IR does not indicate if R #4 was sent to the ER for evaluation. J. On 11/16/22 at 4:06 pm, during an interview with the facility's Resident Care Coordinator, she	A 032	A032-Incident Reporting A. With respect to HOW the facility will CORRECT the problem identified in the deficiency list: 1. Executive Director (ED) or designee will review all incident reports dating back 60 days and ensure all reportable incidents have been reported to the NMDOH in accordance with occurrence reporting guidelines. This audit will be completed on or before January 15th, 2023. ED or designee will review and monitor incidents each workday, and ensure the 5 day report is submitted on time. B. With respect to what the facility will do to PREVENT the same deficiency from recurring: 1. ED and WD will all be in-serviced on reporting requirements and procedures in accordance with NMDOH regulations. In-service will take place on or before January 15th, 2023 and documented on an in-service sign-in sheet.	

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A 032	Continued From page 18 confirmed that the above Internal IRs for R #4, were not reported to the Licensing Authority within 24 hours, or the next business day and the facility did not conduct an investigation and submit a copy of the investigation report to the licensing authority on the above incidents within 5 business days.	A 032		
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 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	A 034	A034 Custodial Drug Permit A. With respect to HOW the facility will CORRECT the problem identified in the deficiency list: 1. Resident #4 no longer resides in the community. B. With respect to what the facility will do to PREVENT the same deficiency from recurring: 1. RVPW or designee will educate ED, WD and WN on ensuring medication orders are complete and dispensing pharmacy received. Training will take place on or before December 31st, 2022 and documented on an in-service sign in sheet. 2. WD or designee will obtain a 3-day emergency supply of medication in the event a medication is unavailable to be administered in accordance with provider order.	

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A 034	Continued From page 19 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 (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	A 034	A034 Custodial Drug Permit A. With respect to HOW the facility will CORRECT the problem identified in the deficiency list: 1. Resident #4 no longer resides in the community. B. With respect to what the facility will do to PREVENT the same deficiency from recurring: 1. RVPW or designee will educate ED, WD and WN on ensuring medication orders are complete and dispensing pharmacy received. Training will take place on or before December 31st, 2022 and documented on an in-service sign in sheet. 2. WD or designee will obtain a 3-day emergency supply of medication in the event a medication is unavailable to be administered in accordance with provider order.	

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A 034	Continued From page 20 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 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. Based on record review and interview, the facility failed to ensure for 1 (R #4) of 7 (R #1-7) residents whose facility records were reviewed for compliance that the residents have available their	A 034	A034 Custodial Drug Permit A. With respect to HOW the facility will CORRECT the problem identified in the deficiency list: 1. Resident #4 no longer resides in the community. B. With respect to what the facility will do to PREVENT the same deficiency from recurring: 1. RVPW or designee will educate ED, WD and WN on ensuring medication orders are complete and dispensing pharmacy received. Training will take place on or before December 31st, 2022 and documented on an in-service sign in sheet. 2. WD or designee will obtain a 3-day emergency supply of medication in the event a medication is unavailable to be administered in accordance with provider order.	

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A 034	Continued From page 21 prescribed medications to take as ordered. This deficient practice could potentially affect the health, safety, and welfare of the 50 (R #s 1-50) residents listed on the census provided by the Resident Care Coordinator on 11/14/22, if the resident misses a dose of their prescribed medications. The findings for R #4 are: A. Record review of R #4's Medication Administration Record (MAR) for 08/2021, revealed that the following medications ordered for R #4 were not available at the facility on [redacted]/21 for the 8:00 pm dose: [redacted] B. On 11/22/22 at 2:18 pm, during an interview with the facility's Resident Care Coordinator, she confirmed the following: 1. R #4 was admitted to the facility on [redacted]/21 at 1:18 pm and did not have any of her prescribed medication from the Assisted Living Facility in Rio Rancho. 2. On 08/04/21 at 2:11 pm, the facility requested R #4's prescribed medications from (Name of Pharmacy) pharmacy via fax and were not received on 08/04/21. 3. On 08/05/21 at 9:24 am, the facility requested again R #4's prescribed medications from (Name of Pharmacy) pharmacy via fax and were not received on 08/05/21. 4. On 08/06/21 at 5:29 pm, the facility contacted (Name of Pharmacy) pharmacy via phone requesting R #4's prescribed medications and were not received on 08/06/21.	A 034	A034 Custodial Drug Permit A. With respect to HOW the facility will CORRECT the problem identified in the deficiency list: 1. Resident #4 no longer resides in the community. B. With respect to what the facility will do to PREVENT the same deficiency from recurring: 1. RVPW or designee will educate ED, WD and WN on ensuring medication orders are complete and dispensing pharmacy received. Training will take place on or before December 31st, 2022 and documented on an in-service sign in sheet. 2. WD or designee will obtain a 3-day emergency supply of medication in the event a medication is unavailable to be administered in accordance with provider order.	

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A 034	Continued From page 22 5. The facility did not attempt on 08/06/21, to obtain R #4's medications listed above from a local pharmacy for the 8:00 pm dose and therefore missed the scheduled 8:00 pm dose.	A 034		
A 035	7 NMAC 8.2.35 Medication MEDICATIONS: Administration of medications or staff assistance with self-administration of medications shall be in accordance with state and federal laws. No medications, including over-the-counter medications, PRN (when needed) medications, or treatment shall be started, changed or discontinued by the facility without an order from the physician, physician assistant or nurse practitioner and with entry into the resident's record. A. State board of nursing licensed or certified health care professionals are responsible for the administration of medications. Administration may 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	A 035	A035 Medication Administration A. With respect to HOW the facility will CORRECT the problem identified in the deficiency list: 1. Resident's #4 no longer resides in the community. B. With respect to what the facility will do to PREVENT the same deficiency from recurring: 1. RVPW or designee will educate all nurses and medication care managers on medication errors and occurrences, completing the Incident Report and notifying prescribing or primary care provider. In-service will be completed on or before December 31st, 2022 and documented on an in-service sign in sheet. 2. WD or designee will bring to QA monthly all medication error reports for review for tracking and trending purposes. This audit will be conducted using an internal QA audit tool.	

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A 035	Continued From page 23 number of doses that may be given in a 24-hour period and indicate under what circumstances the primary care practitioner (PCP) is to be notified. (2) The utilization of PRN medications shall be reviewed routinely. Frequent or escalating use of PRN medications shall be reported to the PCP. D. Only a licensed nurse (RN or LPN) shall administer any medications or conduct any invasive procedures provided by the following routes: intravenous (IV), subcutaneous (SQ), intramuscular (IM), vaginal or rectal. Only a licensed nurse shall administer non-premixed nebulizer treatments. E. The facility shall have medication reference material that contains information relating to drug interactions and side effects on the premises. Staff that assist in the self-administration of medications shall know interactions or possible side effects that might occur. F. Medications prescribed for one resident shall not be used for another resident. G. Medication assistance record (MAR). For residents who are not independent and require assistance with self administration, the facility shall have a MAR that documents the details of the residents' medication, including PRN and over-the-counter medication that is assisted with self-administration by qualified staff or administered to the resident by licensed or certified staff. The information in the MAR shall include: (1) the resident's name; (2) any known allergies to medication that the resident has; (3) the name of the resident's PCP or the prescriber of the medication; (4) the diagnosis or reason for the medication; (5) the name of the medication, including the drug product brand name and the generic name;	A 035	A035 Medication Administration A. With respect to HOW the facility will CORRECT the problem identified in the deficiency list: 1. Resident's #4 no longer resides in the community. B. With respect to what the facility will do to PREVENT the same deficiency from recurring: 1. RVPW or designee will educate all nurses and medication care managers on medication errors and occurrences, completing the Incident Report and notifying prescribing or primary care provider. In-service will be completed on or before December 31st, 2022 and documented on an in-service sign in sheet. 2. WD or designee will bring to QA monthly all medication error reports for review for tracking and trending purposes. This audit will be conducted using an internal QA audit tool.	

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A 035	Continued From page 24 (6) notation if the medication is a schedule II-IV drug; (7) the dosage of the medication; (8) the strength of the medication; (9) the frequency or how often the medication is to be taken or given; (10) the route of delivery for the medication (mouth, eye, ear, other); (11) the method of delivery for the medication (pills, drops, IM injection, other); (12) the date that the medication was started or discontinued; (13) any change in the medication order; (14) pre-medication information (i.e., pulse, respiration, blood pressure, blood sugar) as required by the medication order; (15) the date and time that the medication is self-administered, administered with assistance or is administered; (16) the initials and signature of the person assisting with or administering the medication; (17) the desired results obtained from or problems encountered with the medication (pain relieved, allergic reaction, etc.); (18) any refused dose of medication; (19) any missed dose of medication; and (20) any medication error. H. No medication shall be stopped or started without specific orders from the primary care physician. I. If a resident refuses to take a prescribed medication, it shall be documented and the facility shall report it to the prescriber. J. A suspected adverse reaction to a medication shall be documented on the MAR and reported immediately to the PCP and the resident's surrogate decision maker. If applicable, emergency medical treatment shall be arranged. Documentation of the event shall be kept in the	A 035	A035 Medication Administration A. With respect to HOW the facility will CORRECT the problem identified in the deficiency list: 1. Resident's #4 no longer resides in the community. B. With respect to what the facility will do to PREVENT the same deficiency from recurring: 1. RVPW or designee will educate all nurses and medication care managers on medication errors and occurrences, completing the Incident Report and notifying prescribing or primary care provider. In-service will be completed on or before December 31st, 2022 and documented on an in-service sign in sheet. 2. WD or designee will bring to QA monthly all medication error reports for review for tracking and trending purposes. This audit will be conducted using an internal QA audit tool.	

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A 035	Continued From page 25 resident's record. K. Prescription medication, other than blister packs and unit dose containers, shall be kept in the original container with a pharmacy label that includes the following: (1) the resident's name; (2) the name of the medication; (3) the date that the prescription was issued; (4) the prescribed dosage and the instructions for administration of the medication; and (5) the name and title of the prescriber. L. Any medication that is removed from the pharmacy container or blister pack shall be given immediately and documented by the staff that assisted with the medication delivery. M. The facility shall report all medication errors to the physician, documentation of medication errors and the prescriber's response shall be kept in the resident's record. N. The facility shall develop and follow a written policy for unused, outdated, or recalled medications kept in the facility in accordance with 16.19.11.10 NMAC (AS AMENDED). [7.8.2.35 NMAC - Rp, 7.8.2.35 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: MEDICATIONS 7.8.2.35 M. Based on record review and interview, the facility failed to ensure for 1 (R #4) of 7 (R #1-7) residents whose facility records were reviewed for compliance that: 1. All medication errors shall be reported to the physician;	A 035	A035 Medication Administration A. With respect to HOW the facility will CORRECT the problem identified in the deficiency list: 1. Resident's #4 no longer resides in the community. B. With respect to what the facility will do to PREVENT the same deficiency from recurring: 1. RVPW or designee will educate all nurses and medication care managers on medication errors and occurrences, completing the Incident Report and notifying prescribing or primary care provider. In-service will be completed on or before December 31st, 2022 and documented on an in-service sign in sheet. 2. WD or designee will bring to QA monthly all medication error reports for review for tracking and trending purposes. This audit will be conducted using an internal QA audit tool.	

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A 035	Continued From page 26 2. There be documentation of the medication error; 3. The prescriber's response shall be kept in the resident's record. This deficient practice could potentially affect the health, safety, and welfare of the 50 (R #s 1-50) residents listed on the census provided by the Resident Care Coordinator on 11/14/22, if: 1. A resident misses a scheduled dose of medication which potentially can make the medicine less effective. 2. The facility does not report the medication error to the physician and/or prescriber to identify any possible complications and give further instructions. The findings for R #4 are: A. Record review of R #4's facility record and Medication Administration Record (MAR) for 08/2021, revealed that: 1. R #4 was admitted to the facility on [redacted]21 at 1:18 pm. 2. The following medications ordered for R #4 were missed due to the facility did not have available to give to the resident on 08/06/21 for the 8:00 pm dose: [redacted] 3. There is no documentary evidence that a medication error report was completed. 4. There is no documentary evidence that the resident's physician was notified. 5. There is no documentary evidence of the prescriber's response was in R #4's record.	A 035	A035 Medication Administration A. With respect to HOW the facility will CORRECT the problem identified in the deficiency list: 1. Resident's #4 no longer resides in the community. B. With respect to what the facility will do to PREVENT the same deficiency from recurring: 1. RVPW or designee will educate all nurses and medication care managers on medication errors and occurrences, completing the Incident Report and notifying prescribing or primary care provider. In-service will be completed on or before December 31st, 2022 and documented on an in-service sign in sheet. 2. WD or designee will bring to QA monthly all medication error reports for review for tracking and trending purposes. This audit will be conducted using an internal QA audit tool.	

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A 035	Continued From page 27 B. On 11/22/22 at 2:18 pm, during an interview with the facility's Resident Care Coordinator, she confirmed the above findings for R #4.	A 035		
A 036	7 NMAC 8.2.36 Nutrition NUTRITION: The facility shall provide planned and nutritionally balanced meals from the basic food groups in accordance with the " recommended daily dietary allowance " of the American dietetic association, the food and nutrition board of the national research council, or the national academy of sciences. Meals shall meet the nutritional needs of the residents in accordance with the " 2005 USDA dietary guidelines for Americans. " Vending machines shall not be considered a source of snacks. A. Dietary services policies and procedures. The facility will develop and implement written policies and procedures that are maintained on the premises and that govern the following requirements. (1) Meal service. The facility shall: (a) serve at least three (3) meals or their equivalent each day at regular times with no more than sixteen (16) hours between the evening meal and morning meal with snacks freely available; (b) provide snacks of nourishing quality and post on the daily menu; (c) develop menus enjoyed by the residents and served at normal intervals appropriate to the residents ' preferences; (d) post the weekly menu, including snacks where residents and families are able to view it; posted menus shall be followed and any substitution shall be of equivalent nutritional value and recorded on the posted menu; identical menus shall not be used within a one (1) week	A 036	A036 Nutrition A. With respect to HOW the facility will CORRECT the problem identified in the deficiency list: 1. All trash receptacle in the kitchen have been replaced with ones with lids. B. With respect to what the facility will do to PREVENT the same deficiency from recurring: 1. ED or designee will educate all culinary staff on the requirement for trash receptacles to be covered. Training will take place on or before December 31st and documented on an in-service sign in sheet.	

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A 036	Continued From page 28 cycle; (e) have special menus or meal items following guidelines from the resident ' s physician for residents who have medically prescribed special diets; (f) serve all residents in a dining room except for residents with a temporary illness, or with documented specific personal preference to have meals in their room; (g) allow sufficient time for meals to enable residents to eat at a leisurely pace and to socialize; and (h) contact the resident ' s PCP within forty-eight (48) hours if a resident consistently refuses to eat. (2) Staff in-service training. The facility shall provide an in-service training program for staff that are involved in food preparation at orientation and at least annually and that includes: (a) instruction in proper food storage; (b) preparation and serving food; (c) safety in food handling; (d) appropriate personal hygiene; and (e) infectious and communicable disease control. B. Dietary records. The facility shall maintain the following documentation onsite: (1) a systematic record of all menus and revisions, including snacks, for a minimum of thirty (30) calendar days; (2) a systematic record of therapeutic diets as prescribed by a PCP; (3) a copy of the most recent licensing inspection and for facilities with 10 or more residents, a copy of the New Mexico environment department inspection with notations made by the facility of action taken to comply with recommendations or citations; and (4) a daily log of the recorded temperatures for all facility refrigerators, freezers and steam tables	A 036	A036 Nutrition A. With respect to HOW the facility will CORRECT the problem identified in the deficiency list: 1. All trash receptacle in the kitchen have been replaced with ones with lids. B. With respect to what the facility will do to PREVENT the same deficiency from recurring: 1. ED or designee will educate all culinary staff on the requirement for trash receptacles to be covered. Training will take place on or before December 31st and documented on an in-service sign in sheet.	

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A 036	Continued From page 29 maintained and available for inspection for thirty (30) calendar days. C. Clean and sanitary conditions. All practices shall be in accordance with the standards of the state environment department, pursuant to 7.6.2 NMAC. (1) Kitchen sanitation. (a) Equipment and work areas shall be clean and in good repair. Surfaces with which food or beverages come into contact shall be of smooth, impervious material free of open seams, not readily corrodible and easily accessible for cleaning. (b) Utensils shall be stored in a clean, dry place protected from contamination. (c) The walls, ceiling and floors of all rooms that food or drink is stored, prepared or served shall be kept clean and in good repair. (2) Washing and sanitizing kitchenware. (a) All reusable tableware and kitchenware shall be cleaned in accordance with procedures that include separate steps for prewashing, washing, rinsing and sanitizing. (b) Proper dishwashing procedures and techniques shall be utilized and understood by the dishwashing staff. (c) Periodic monitoring of the operation of the detergent dispenser, washing, rinsing and sanitizing temperatures shall be performed and documented. (d) When a dishwashing machine is utilized, the cleanliness of the machine, its jets and its thermostatic controls shall be monitored and documented by the facility. A monthly log of the recorded temperature of the dishwasher shall be maintained in the facility and available for inspection. (3) Sinks for hand washing shall include hot and cold running water, hand-washing soap and	A 036	A036 Nutrition A. With respect to HOW the facility will CORRECT the problem identified in the deficiency list: 1. All trash receptacle in the kitchen have been replaced with ones with lids. B. With respect to what the facility will do to PREVENT the same deficiency from recurring: 1. ED or designee will educate all culinary staff on the requirement for trash receptacles to be covered. Training will take place on or before December 31st and documented on an in-service sign in sheet.	

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A 036	Continued From page 30 disposable towels. (4) All garbage and kitchen refuse that is not disposed of through a garbage disposal unit shall be kept in watertight containers with close-fitting covers and disposed of daily in a safe and sanitary manner. (5) Cooks and food handlers shall wear clean outer garments and hair nets or caps and shall keep their hands clean at all times when engaged in handling food, drink, utensils or equipment in accordance with the local health authority. Disposable gloves shall be used in accordance with the local health authority. D. Food management. The facility shall store, prepare, distribute and serve food under sanitary conditions and in accordance with the regulations governing food establishments of local health authority having jurisdiction, 7.6.2 NMAC. (1) The facility shall ensure that a minimum of a three (3) calendar day supply of perishables and a five (5) calendar day supply of non-perishables or canned foods is available for the residents. (2) The facility refrigerator and freezer shall have an accurate thermometer which reads within or not more than plus or minus three (3) degrees fahrenheit of the required temperature, located in the warmest section of the refrigerator and freezer and shall be accessible and easily read. (a) The temperature of the refrigerator shall be thirty-five (35) - forty-one (41) degrees fahrenheit. (b) Freezer temperatures shall be maintained at zero (0) degrees fahrenheit or below. (3) Refrigerators and freezers shall be kept clean and sanitary at all times. Food stored in refrigerators and freezers shall be covered, dated and labeled. Unused leftover food shall be discarded after three (3) calendar days. (4) Steam tables, hot food tables, slow cookers, crock pots and other hot food holding devices	A 036	A036 Nutrition A. With respect to HOW the facility will CORRECT the problem identified in the deficiency list: 1. All trash receptacle in the kitchen have been replaced with ones with lids. B. With respect to what the facility will do to PREVENT the same deficiency from recurring: 1. ED or designee will educate all culinary staff on the requirement for trash receptacles to be covered. Training will take place on or before December 31st and documented on an in-service sign in sheet.	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 036	Continued From page 31 shall not be used in heating or reheating food. Hot food temperatures shall be checked periodically to insure that a minimum of one hundred forty (140) degrees fahrenheit is maintained. (5) Medication, biological specimens, poisons, detergents and cleaning supplies shall not be kept in the same storage areas used for storage of foods. Medications shall not be stored in the refrigerator with food; an alternate refrigerator for medication shall be used pursuant to Subsection B of 7.6.2.8 NMAC. (6) Canned or preserved foods shall be procured from sources that process the food under regulated quality and sanitation controls. This does not preclude the use of local fresh produce. The facility shall not use home-canned foods. (7) Dry or staple food items shall be stored at least six (6) inches off the floor in a ventilated room that is not subject to sewage, waste water back-flow or contamination by condensation, leakage, rodents or vermin. (8) The facility shall ensure the following: (a) all perishable food is refrigerated and the temperature is maintained no higher than forty-one (41) degrees fahrenheit; (b) the temperature for all hot foods is maintained at one hundred forty (140) degrees fahrenheit; and (c) all displayed or transported food is protected from environmental contamination and maintained at proper temperatures in clean containers, cabinets or serving carts. E. Milk. (1) Raw milk shall not be used. (2) Condensed, evaporated, or dried milk products that are nationally recognized may be employed as " additives " in cooked food preparation but shall not be substituted or served	A 036	A036 Nutrition A. With respect to HOW the facility will CORRECT the problem identified in the deficiency list: 1. All trash receptacle in the kitchen have been replaced with ones with lids. B. With respect to what the facility will do to PREVENT the same deficiency from recurring: 1. ED or designee will educate all culinary staff on the requirement for trash receptacles to be covered. Training will take place on or before December 31st and documented on an in-service sign in sheet.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	4107	A. BUILDING: _____ B. WING _____	C 11/23/2022

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A 036	Continued From page 32 to residents in place of milk. F. Collateral requirements. Compliance with this rule does not relieve a facility from the responsibility of meeting more stringent municipal regulations, ordinances or other requirements of state or federal laws governing food service establishments. Local health authority having jurisdiction means municipal, county, state or federal agency(s) that have laws and regulations governing food establishments, liquid waste disposal, treatment facilities and private wells. [7.8.2.36 NMAC - Rp, 7.8.2.37 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.36 C. (4) Based on observation and interview the facility failed to ensure that the trash cans in the kitchen had close-fitting covers. This deficient practice could likely result in the 50 (R #s 1- 50) residents identified on the census provided by Resident Care Coordinator on 11/14/22, to be at risk of contracting foodborne illness by ingesting food contaminated by bacteria and germs because the trash cans do not have close-fitting covers. The findings are: A. On 11/14//22 at 11:20 am, during observation of the facility kitchen, four (4) trash cans were observed to not have close-fitting covers. B. On 11/14/22 at 11:25 am, during an interview with the Executive Chef, he confirmed that the	A 036	A036 Nutrition A. With respect to HOW the facility will CORRECT the problem identified in the deficiency list: 1. All trash receptacle in the kitchen have been replaced with ones with lids. B. With respect to what the facility will do to PREVENT the same deficiency from recurring: 1. ED or designee will educate all culinary staff on the requirement for trash receptacles to be covered. Training will take place on or before December 31st and documented on an in-service sign in sheet.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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A 036	Continued From page 33 four (4) kitchen trash cans did not have close-fitting covers.	A 036	A036 Nutrition A. With respect to HOW the facility will CORRECT the problem identified in the deficiency list: 1. All trash receptacle in the kitchen have been replaced with ones with lids. B. With respect to what the facility will do to PREVENT the same deficiency from recurring: 1. ED or designee will educate all culinary staff on the requirement for trash receptacles to be covered. Training will take place on or before December 31st and documented on an in-service sign in sheet.	