Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	4029	A. BUILDING: _____ B. WING _____	C 06/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALBUQUERQUE UPTOWN ASSISTED LIVING, INC	7611 INDIAN SCHOOL RD NE ALBUQUERQUE, NM 87110

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 000	Initial Comments The following deficiencies were cited during a Full-Onsite/Complaint survey completed on 06/12/23 for the state requirements of 7 NMAC 8.2, Regulations for Assisted Livings for Adults. Complaint Intake #NM60788 was investigated with deficiencies cited. Complaint Intake #NM62115 was investigated with deficiencies cited. Resident Census is 22.	A 000		
A 017	7 NMAC 8.2.17 Staff Training STAFF TRAINING: A. Training and orientation for each new employee and volunteer that provides direct care shall include a minimum of sixteen (16) hours of supervised training prior to providing unsupervised care for residents. B. Documentation of orientation and subsequent trainings shall be kept in the personnel file at the facility. C. Training shall be provided at orientation and at least twelve (12) hours annually, the orientation, training and proof of competency shall include: (1) fire safety and evacuation training; (2) first aid; (3) safe food handling practices (for persons involved in food preparation), to include: (a) instructions in proper storage; (b) preparation and serving of food; (c) safety in food handling; (d) appropriate personal hygiene; and (e) infectious and communicable disease control; (4) confidentiality of records and resident information; (5) infection control; (6) resident rights;	A 017	All staff members have completed their 16 hrs. of training the first two days of working. Staff members are working on completing their 12 hours annual trainings thru a training agency Administrator & Mgr. monitor testing on a monthly basis. Reminders are sent out on the 3rd week of every month. Monthly employee reminders (in house meeting.) Log book must be signed every month.	10-31-2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	4029	A. BUILDING: _____ B. WING _____	C 06/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALBUQUERQUE UPTOWN ASSISTED LIVING, INC	7611 INDIAN SCHOOL RD NE ALBUQUERQUE, NM 87110

(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 017	Continued From page 1 (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 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 A B C (1-12) Based on record review and interview, the facility failed to ensure that: 1. The Direct Care Staff (DCS) received: a. 16 hours of supervised training prior to providing unsupervised care. b. 12 hours of orientation and/or annual training required by regulation. 2. Documentation of the completed trainings were maintained onsite and available for review. These deficient practices could likely result in the 22 (R #s 1-22) residents listed on the resident census, provided by the Owner on 06/05/23, 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 017		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	4029	A. BUILDING: _____ B. WING _____	C 06/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALBUQUERQUE UPTOWN ASSISTED LIVING, INC	7611 INDIAN SCHOOL RD NE ALBUQUERQUE, NM 87110

(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 017	Continued From page 2 A. Record review of DCS #1's (hire date 04/05/21) training file, revealed no documentation of completing the following required trainings: 1. 16-hours of supervised training prior to providing unsupervised care for the residents 2. 12-hours of orientation/annual training in the following required 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 (c) safety in food handling (d) appropriate personal hygiene (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 (12) the proper way to implement a resident ISP (Individual Service Plan) for staff that assist with ISPs B. On 06/07/23 at 1:55 pm, during an interview	A 017		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	4029	A. BUILDING: _____ B. WING _____	C 06/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALBUQUERQUE UPTOWN ASSISTED LIVING, INC	7611 INDIAN SCHOOL RD NE ALBUQUERQUE, NM 87110

(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 017	Continued From page 3	A 017		

with DCS #1, she stated that she did complete:
1. The 16 hours of supervised training, before providing unsupervised care to residents when she started.
2. Portions of the 12 hours or the required orientation/annual trainings.

C. Record review of DCS #2's (hire date 02/23/23) training files, revealed no documentation of completing the following required trainings:
1. 16-hours of supervised training prior to providing unsupervised care for the residents
2. 12-hours of orientation training in the following required 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
(c) safety in food handling
(d) appropriate personal hygiene
(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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	4029	A. BUILDING: _____ B. WING _____	C 06/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALBUQUERQUE UPTOWN ASSISTED LIVING, INC	7611 INDIAN SCHOOL RD NE ALBUQUERQUE, NM 87110

(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 017	Continued From page 4 (11) medication assistance, including the certificate of training for staff that assist with medication delivery (12) the proper way to implement a resident ISP for staff that assist with ISPs D. Record review of DCS #3's (hire date 03/20/23) training files, revealed no documentation of completing the following required trainings: 1. 16-hours of supervised training prior to providing unsupervised care for the residents 2. 12-hours of orientation training in the following required 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 (c) safety in food handling (d) appropriate personal hygiene (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	A 017		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	4029	A. BUILDING: _____ B. WING _____	C 06/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALBUQUERQUE UPTOWN ASSISTED LIVING, INC	7611 INDIAN SCHOOL RD NE ALBUQUERQUE, NM 87110

(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 017	Continued From page 5	A 017		

certificate of training for staff that assist with medication delivery
(12) the proper way to implement a resident ISP for staff that assist with ISPs

E. Record review of DCS #4's (hire date 04/17/23) training files, revealed no documentation of completing the following required trainings:
1. 16-hours of supervised training prior to providing unsupervised care for the residents.
2. 12-hours of orientation training in the following required 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
(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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	4029	A. BUILDING: _____ B. WING _____	C 06/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALBUQUERQUE UPTOWN ASSISTED LIVING, INC	7611 INDIAN SCHOOL RD NE ALBUQUERQUE, NM 87110

(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 017	Continued From page 6 medication delivery (12) the proper way to implement a resident ISP for staff that assist with ISPs F. On 06/07/23 at 11:20 am, during an interview with the Administrator, she confirmed that DCS #s 1-4 did not have documentation of completing the required 16-hours of supervised training prior to providing unsupervised care for the residents. G. On 06/07/23 at 11:40 am, during an interview with the Administrator, she confirmed that DCS #s 1-4 have not completed all of the above required 12-hours of orientation/annual trainings.	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; (2) the program narrative; (3) the facility's rules; (4) the cost of services and the method of payment; (5) the refund provision in case of death, transfer, voluntary or involuntary discharge; (6) information to formulate advance directives; (7) a written description of the legal rights of the residents translated into another language, if necessary;	A 020		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	4029	A. BUILDING: _____ B. WING _____	C 06/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALBUQUERQUE UPTOWN ASSISTED LIVING, INC	7611 INDIAN SCHOOL RD NE ALBUQUERQUE, NM 87110

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 020	Continued From page 7 (8) the facility's staffing ratio; (9) written authorization for staff to assist with medications; (10) notification of rights and responsibilities pursuant to the Incident Reporting Intake, Processing and Training Requirements, 7.1.13 NMAC; (11) the facility ' s bed hold policy; and (12) the admission agreement may be terminated if an appropriate placement is found for the resident, under the following circumstances: (a) there shall be a fifteen (15) day written notice of termination given to the resident or his or her surrogate decision maker, unless the resident requests the termination; (b) the resident has failed to pay for a stay at the facility as defined in the admission agreement; (c) the facility ceases to operate or is no longer able to provide services to the resident; (d) the resident ' s health has improved sufficiently and therefore no longer requires the services of the facility; (e) termination without prior notice is permitted in emergency situations for the following reasons: (i) the transfer or discharge is necessary for the resident's safety and welfare; (ii) the resident's needs cannot safely be met in the facility; or (iii) the safety and health of other residents and staff in the facility are endangered; (13) the facility shall provide a thirty (30) day written notice to residents regarding any changes in the cost or the material services provided; a new or amended admission agreement must be executed whenever services, costs or other material terms are changed; and (14) facilities representing their services as " specialized " must disclose evidence of staff specialty training to prospective residents.	A 020		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	4029	A. BUILDING: _____ B. WING _____	C 06/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALBUQUERQUE UPTOWN ASSISTED LIVING, INC	7611 INDIAN SCHOOL RD NE ALBUQUERQUE, NM 87110

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 020	Continued From page 8 B. Restrictions in admission. The facility shall not admit or retain individuals that require twenty-four (24) hour continuous nursing care, refer to Subsection U of 7.8.2.7 NMAC Definitions. This rule does not apply to hospice residents who have elected to receive the hospice benefit. Conditions or circumstances that usually require continuous nursing care may include but are not limited to the following: (1) ventilator dependency; (2) pressure sores and decubitus ulcers (stage III or IV); (3) intravenous therapy or injections; (4) any condition requiring either physical or chemical restraints; (5) nasogastric tubes; (6) tracheostomy care; (7) residents that present an imminent physical threat or danger to self or others; (8) residents whose psychological or physical condition has declined and placement in the current facility is no longer appropriate as determined by the PCP; (9) residents with a diagnosis that requires isolation techniques; (10) residents that require the use of a Hoyer lift; and (11) ostomy (unless resident is able to provide self care). C. Exceptions to admission, readmission and retention. If a resident requires a greater degree of care than the facility would normally provide or is permitted to provide and the resident wishes to be re-admitted or remain in the facility and the facility wishes to re-admit or retain the resident. The facility shall comply with the following requirements. (1) Convene a team, comprised of: (a) the facility administrator and a facility health	A 020		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	4029	A. BUILDING: _____ B. WING _____	C 06/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALBUQUERQUE UPTOWN ASSISTED LIVING, INC	7611 INDIAN SCHOOL RD NE ALBUQUERQUE, NM 87110

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 020	Continued From page 9	A 020		

care professional if desired;
(b) the resident or resident ' s surrogate decision maker; and
(c) the hospice or home health clinician.
(2) The team shall jointly determine if the resident should be admitted, readmitted or allowed to remain in the facility. Team approval shall be in writing, signed and dated by all team members and the approval shall be maintained in the resident's record and shall:
(a) be based upon an individual service plan (ISP) which identifies the resident's specific needs and addresses the manner that such needs will be met;
(b) ensure that if the facility is licensed for more than eight (8) residents and does not have complete fire sprinkler coverage, the facility shall maintain an evacuation rating score of prompt as determined by the fire safety equivalency system (FSES);
(c) evaluate and outline how meeting the specific needs of the resident will impact the staff and the other residents; and
(d) include an independent advocate such as a certified ombudsman if requested by the resident, the family or the facility.
(3) The team recommendation shall be maintained on site in the resident ' s file.
(4) When a resident is discharged, the facility shall record where the resident was discharged to and what medications were released with the resident.
D. Coordination of care.
(1) Assisted living facilities shall have evidence of care coordination on an ISP for all services that are provided in the facility by an outside health care provider, such as hospice or home health providers.
(2) Residents shall be given a list of providers,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	4029	A. BUILDING: _____ B. WING _____	C 06/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALBUQUERQUE UPTOWN ASSISTED LIVING, INC	7611 INDIAN SCHOOL RD NE ALBUQUERQUE, NM 87110

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 020	Continued From page 10 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 A (5) Refer to Senate Bill (SB) 0335 - 2013 AN ACT RELATING TO HEALTH CARE; REQUIRING CONTRACTS FOR ASSISTED LIVING FACILITIES TO CONTAIN A REFUND POLICY UPON TERMINATION OF A CONTRACT DUE TO THE DEATH OF THE RESIDENT; PROVIDING FOR STORAGE OF A RESIDENT'S BELONGINGS; DECLARING AN EMERGENCY. BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF NEW MEXICO: SECTION 1. A new section of the Public Health Act is enacted to read: "ASSISTED LIVING FACILITIES CONTRACTS--LIMIT ON CHARGES AFTER RESIDENT DEATH.-- A. The contract for each resident of an assisted living facility shall include a refund policy to be implemented at the time of a resident's death. The refund policy shall provide that the resident's 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	A 020		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	4029	A. BUILDING: _____ B. WING _____	C 06/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALBUQUERQUE UPTOWN ASSISTED LIVING, INC	7611 INDIAN SCHOOL RD NE ALBUQUERQUE, NM 87110

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 020	Continued From page 11	A 020		

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 6 (R #s 1 - 6) of 6 (R #s 1 - 6) residents whose Admission/Discharge Agreements were reviewed for compliance, that the Admission/Discharge Agreements included a refund upon death policy that was in compliance with NMAC 7.8.2.20 and (SB) 0335 - 2013.

This deficient 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 may have occurred.

The findings are:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	4029	A. BUILDING: _____ B. WING _____	C 06/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALBUQUERQUE UPTOWN ASSISTED LIVING, INC	7611 INDIAN SCHOOL RD NE ALBUQUERQUE, NM 87110

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 020	Continued From page 12 A. Record review of R #1's Admission/Discharge Agreement dated [redacted] revealed no documentation of a refund upon death policy that was in compliance with NMAC 7.8.2.20 and (SB) 0335 - 2013. B. Record review of R #2's Admission/Discharge Agreement dated [redacted] revealed no documentation of a refund upon death policy that was in compliance with NMAC 7.8.2.20 and (SB) 0335 - 2013. C. Record review of R #3's Admission/Discharge Agreement dated [redacted] revealed no documentation of a refund upon death policy that was in compliance with NMAC 7.8.2.20 and (SB) 0335 - 2013. D. Record review of R #4's Admission/Discharge Agreement dated [redacted] revealed no documentation of a refund upon death policy that was in compliance with NMAC 7.8.2.20 and (SB) 0335 - 2013. E. Record review of R #5's Admission/Discharge Agreement dated [redacted] revealed no documentation of a refund upon death policy that was in compliance with NMAC 7.8.2.20 and (SB) 0335 - 2013. F. Record review of R #6's Admission/Discharge Agreement dated [redacted] revealed no documentation of a refund upon death policy that was in compliance with NMAC 7.8.2.20 and (SB) 0335 - 2013. G. On 06/12/23 at 8:10 am, during an interview with the Owner/Office Manager, she confirmed that the Admission/Discharge Agreements for R	A 020		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	4029	A. BUILDING: _____ B. WING _____	C 06/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALBUQUERQUE UPTOWN ASSISTED LIVING, INC	7611 INDIAN SCHOOL RD NE ALBUQUERQUE, NM 87110

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 020	Continued From page 13 #s 1 - 6 did not contain a refund upon death policy that was in compliance with NMAC 7.8.2.20 and (SB) 0335 - 2013.	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; (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;	A 025		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	4029	A. BUILDING: _____ B. WING _____	C 06/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALBUQUERQUE UPTOWN ASSISTED LIVING, INC	7611 INDIAN SCHOOL RD NE ALBUQUERQUE, NM 87110

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 025	Continued From page 14 (12) nutritional status; (13) oral or dental status; (14) skin conditions; (15) medication use and level of assistance needed with medications; (16) special treatments and procedures or special medical needs such as hospice; and (17) safety needs/high risk behaviors; history of falls agitation, wandering, fire safety issues, etc. D. The resident evaluation shall include a history and physical examination and an evaluation report by a physician or a physician extender within six (6) months of admission. A resident shall have a medical evaluation by a physician or a physician extender at least annually. E. The resident evaluation shall be reviewed and if needed revised by a licensed practical nurse, registered nurse or physician extender at the time the individual service plan is reviewed, at a minimum of every six (6) months or when a significant change in health status occurs. [7.8.2.25 NMAC - Rp, 7.8.2.25 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.25 A Based on record review and interview, the facility failed to ensure for 5 (R #s 1-4, 6) of 5 (R #s 1-4, 6) residents whose evaluations were reviewed for compliance, that they were completed within 15 days prior to admission. This deficient practice could likely result in the residents not receiving appropriate care/services upon admission if the Direct Care Staff (DCS) are not aware of what the	A 025		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	4029	A. BUILDING: _____ B. WING _____	C 06/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALBUQUERQUE UPTOWN ASSISTED LIVING, INC	7611 INDIAN SCHOOL RD NE ALBUQUERQUE, NM 87110

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 025	Continued From page 15 resident's needs are. The findings are: A. Record review of R #1's resident file (admitted on [redacted] revealed no documentation that a resident evaluation was ever completed. B. Record review of R #2's evaluation dated 03/26/23, revealed that the evaluation was not completed within 15-days prior to admission on [redacted] C. Record review of R #3's evaluation dated 03/31/23, revealed that the evaluation was not completed within 15-days prior to admission on [redacted] D. Record review of R # 4's resident file (admitted on [redacted] revealed no documentation that a resident evaluation was ever completed. E. Record review of R # 6's resident file (admitted on [redacted] revealed no documentation that a resident evaluation was ever completed. F. On 06/06/23 at 1:20 pm, during an interview with the Administrator, she confirmed that R #s 1, 4 and 6's initial evaluations were never completed and that R #s 2 and 3's evaluations were not completed within 15-days prior to admission.	A 025		
A 026	7 NMAC 8.2.26 Individual Service Plan INDIVIDUAL SERVICE PLAN (ISP): An ISP shall be developed and implemented within ten (10) calendar days of admission for each resident residing in the facility. A. The ISP shall address those areas of need as	A 026		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	4029	A. BUILDING: _____ B. WING _____	C 06/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALBUQUERQUE UPTOWN ASSISTED LIVING, INC	7611 INDIAN SCHOOL RD NE ALBUQUERQUE, NM 87110

(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 026	Continued From page 16 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 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:	A 026		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	4029	A. BUILDING: _____ B. WING _____	C 06/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALBUQUERQUE UPTOWN ASSISTED LIVING, INC	7611 INDIAN SCHOOL RD NE ALBUQUERQUE, NM 87110

(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 026	Continued From page 17 7.8.2.26 B (7) Based on record review and interview, the facility failed to ensure for 5 (R #s 1-4, 6) of 5 (R #s 1-4, 6) residents whose Individual Service Plans (ISP's) were reviewed for compliance that ISP's were completed within 10 days of admission and included goals and outcomes. These deficient practices could likely result in residents not receiving the care and services needed, or achieving the desired goals and outcomes; because the Direct Care Staff (DCS) do not know what care/services they are to provide. The findings are: Regarding ISPs not completed within 10-days A. Record review of R #2's Individual Service Plan (ISP) dated 03/17/23, revealed that the ISP was not completed within 10-days after admission on [redacted] B. Record review of R #3's ISP dated 03/18/23, revealed that the ISP was not completed within 10-days after admission on [redacted] C. Record review of R #4's ISP dated 04/04/23, revealed that the ISP was not completed within 10-days after admission on [redacted] D. Record review of R #6's file, revealed that the ISP was never completed within 10-days after admission on [redacted] E. On 06/06/23 at 1:20 pm, during an interview with the Administrator, she confirmed that R #s 2-4 ISP's were not completed within 10-days after	A 026		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	4029	A. BUILDING: _____ B. WING _____	C 06/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALBUQUERQUE UPTOWN ASSISTED LIVING, INC	7611 INDIAN SCHOOL RD NE ALBUQUERQUE, NM 87110

(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 026	Continued From page 18 admission. F. On 06/07/23 at 2:06 pm, during an interview with the Administrator, she confirmed that R #6's ISP was not ever completed after [redacted] admission on [redacted] Regarding ISP goals and outcomes G. Record review of R #1's ISP dated [redacted] revealed that the ISP did not include goals and outcomes. H. Record review of R #2's ISP dated [redacted], revealed that the ISP did not include goals and outcomes. I. Record review of R #3's ISP dated [redacted] revealed that the ISP did not include goals and outcomes. J. Record review of R #4's ISP dated [redacted] revealed that the ISP did not include goals and outcomes. K. On 06/06/23 at 1:20 pm, during an interview with the Administrator, she confirmed that R #s 1-4 ISP's did not include goals and outcomes.	A 026		
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	A 032		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	4029	A. BUILDING: _____ B. WING _____	C 06/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALBUQUERQUE UPTOWN ASSISTED LIVING, INC	7611 INDIAN SCHOOL RD NE ALBUQUERQUE, NM 87110

(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 032	Continued From page 19	A 032		

staff to the licensing authority complaint hotline within twenty-four (24) hours or by the next business day, if it is a weekend or a holiday.
(2) The facility shall not delay a report to the complaint hotline while an internal investigation is conducted.
B. The facility is responsible for conducting and documenting the investigation of all incidents within five (5) business days and shall submit a copy of the investigation report to the licensing authority. A copy of the report and the documentation, including the date and time that it was submitted to the licensing authority, shall be maintained on file at the facility. The investigation shall include the following:
(1) a narrative description of the incident;
(2) the result of the facility's investigation shall be recorded on the state approved incident report form for the current year, pursuant to 7.1.13 NMAC; and
(3) plans for further actions in response to the incident.
[7.8.2.32 NMAC - Rp, 7.8.2.32 NMAC, 01/15/2010]

This REQUIREMENT is not met as evidenced by:
7.8.2.32 A (1-2) B

7.1.13 INCIDENT REPORTING, INTAKE, PROCESSING AND TRAINING REQUIREMENTS

Refer to 7.1.13. & A. (1) (2)

W. " Reportable incident " means possible abuse, neglect, exploitation, injuries of unknown origin and other events including but not limited to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	4029	A. BUILDING: _____ B. WING _____	C 06/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALBUQUERQUE UPTOWN ASSISTED LIVING, INC	7611 INDIAN SCHOOL RD NE ALBUQUERQUE, NM 87110

(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 032	Continued From page 20	A 032		

falls which cause injury, unexpected death, elopement, medication error which causes or is likely to cause harm, failure to follow a doctor's order or an ISP or any other incident which may evidence abuse, neglect, or exploitation.

B. (2) Division incident report form and notification by licensed health care facilities: The licensed health care facility shall report incidents utilizing the division's incident report form consistent with the requirements of the division's incident management system guide and CMS regulations as applicable. The licensed health care facility shall ensure that all incident report forms alleging abuse, neglect, exploitation, injuries of unknown origin or other reportable incidents are submitted by a reporter with direct knowledge of an incident, are completed on the bureau's incident report form and received by the division within twenty-four (24) hours of an incident or allegation of an incident or the next business day if the incident occurs on a weekend or a holiday. The licensed health care facility shall ensure that the reporter with the most direct knowledge of the incident assists with the preparation of the incident report form.

Based on record review and interview, the facility failed to ensure for 1 (R #5) of 1 (R #5) resident whose Internal Incident Reports was reviewed for compliance; that any incident or unusual occurrence which has or could threaten the health, safety or welfare of the residents:
1. Were reported to the Licensing Authority within 24-hours, or the next business day if a holiday or weekend.
2. That internal investigations were conducted by the facility, and investigation follow-up reports were submitted to the Licensing Authority within five (5) business days from the dates the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	4029	A. BUILDING: _____ B. WING _____	C 06/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALBUQUERQUE UPTOWN ASSISTED LIVING, INC	7611 INDIAN SCHOOL RD NE ALBUQUERQUE, NM 87110

(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 032	Continued From page 21	A 032		

incidents occurred.

These deficient practices could likely result in the residents to be at risk of harm, injury, and/or death, if incidents of possible abuse, neglect, exploitation, or unusual occurrence occur and there is no oversight by the Licensing Authority.

The findings are:

A. Record review of R #5's Internal Incident Report dated [redacted] at [redacted] revealed:
1. The resident was sitting in a showerchair, leaned forward, grabbed the handrail (unknown if the handrail was on the wall or showerchair) and [redacted] feet slipped backwards. [redacted] did not let go of the handrail, [redacted] body swung around, and [redacted] scraped [redacted] chest with [redacted] thumbnail, causing a skin tear.
2. The resident hit [redacted] right brow on shower floor, causing laceration to [redacted] forehead, pressure was applied, and the bleeding stopped.

B. Record review of R 5's Emergency Room (ER) After Visit Summary dated 06/19/23 revealed the following:
1. The reason for the visit was a fall.
2. R #5 received the following Diagnoses:
   a. [redacted].
   b. [redacted]
   c. [redacted]
   d. [redacted]

C. On [redacted] at 9:10 am, during an interview with DCS #7, she stated that R #5 did go out to the ER, however, [redacted] was not admitted, and returned to the facility on the same day.

D. Record review of the facility's Internal Incident Reports and R #5's resident file, revealed no

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	4029	A. BUILDING: _____ B. WING _____	C 06/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALBUQUERQUE UPTOWN ASSISTED LIVING, INC	7611 INDIAN SCHOOL RD NE ALBUQUERQUE, NM 87110

(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 032	Continued From page 22 documentation that R #5's fall in the shower with injury was: 1. Was reported to the Licensing Authority within twenty-four (24) hours or the next business day if a holiday or weekend. 2. That the facility conducted an internal investigation and/or that a follow-up investigation report was submitted to the Licensing Authority within five (5) business days after the date of the incident. E. On 06/08/23 at 10:15 am, during an interview with the Owner/Office Manager, she confirmed that the facility failed to: 1. Report the above listed incident to the Licensing Authority within twenty-four (24) hours or the next business day if a holiday or weekend. 2. Submit an investigation follow-up report to the Licensing Authority within five (5) business days from the date of the incident.	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	A 034	Permit is current. An appointee will monitor all permits and licenses to insure they are current. We have a sheet of all permits and licenses with due dates. All medications will be maintained by a designated appointee. Meds are ordered and monitored by a designated appointee.	6-26-2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	4029	A. BUILDING: _____ B. WING _____	C 06/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALBUQUERQUE UPTOWN ASSISTED LIVING, INC	7611 INDIAN SCHOOL RD NE ALBUQUERQUE, NM 87110

(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 034	Continued From page 23 in a locked room, as approved by the board of pharmacy and the key shall be in the care of the administrator or designee. (2) Internal medication shall be kept separate from external medications. Drugs to be taken by mouth shall be separated from all other delivery forms. (3) A separate, locked refrigerator shall be provided by the facility for medications. The refrigerator temperature shall be kept in compliance with the state board of pharmacy requirements for medications. (4) All medications, including non-prescription medications, shall be stored in separate compartments for each resident and all medications shall be labeled with the resident's name. (5) A resident may be permitted to keep his or her own medication in a locked compartment in his or her room for self-administration, if the physician's order deems it appropriate. (6) The facility shall not require the residents to purchase medications from any particular pharmacy. (7) Medical gases (oxygen) and equipment used for the administration of inhalation therapy and for resuscitative purposes shall comply with the national fire protection association (NFPA) 99. (8) A proof of use record shall be maintained separately for each schedule II through IV drug (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;	A 034	Meds are ordered on Monday mornings with the nurse. Mgr. on shift Monday morning is responsible to get all meds ordered with the nurse.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	4029	A. BUILDING: _____ B. WING _____	C 06/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALBUQUERQUE UPTOWN ASSISTED LIVING, INC	7611 INDIAN SCHOOL RD NE ALBUQUERQUE, NM 87110

(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 034	Continued From page 24 (f) the signature of the person assisting with delivery of the medication; and (g) the balance of medication remaining. (9) Any remaining medication discontinued by a physician ' s order, or upon discharge or death of the resident shall be inventoried and moved to a separate locked storage container. Such discontinued medications shall be destroyed upon the next quarterly visit by the consulting pharmacist in accordance with 16.19.11.10 NMAC. (10) The record of medication destruction shall be signed by the administrator or designee and the pharmacist and shall be kept on file at the facility. B. Consulting pharmacist. The facility shall maintain records demonstrating that the consulting pharmacist provides the following oversight and guidance. (1) Reviews the medication regimen as needed, but at least quarterly/every three (3) months, to determine that all medications and records are accurate and current. All irregularities shall be reported to the administrator of the facility and these irregularities shall be resolved by the administrator within seventy-two (72) hours. (2) A system of records of receipt and disposition of all drugs in sufficient detail to enable an accurate reconciliation. (3) Consultation shall be provided on all aspects 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	A 034		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	4029	A. BUILDING: _____ B. WING _____	C 06/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALBUQUERQUE UPTOWN ASSISTED LIVING, INC	7611 INDIAN SCHOOL RD NE ALBUQUERQUE, NM 87110

(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 034	Continued From page 25 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: 7.8.2.34 A Based on observation and interview, the facility failed to ensure for 2 (R #s 2 and 4) of 4 (R #s 1-4) residents whose medications were reviewed for compliance that their medications were available at the facility. This deficient practice could likely result in all residents to be at risk of harm, injury, and death if prescribed medications are not available to be taken when needed. The findings are: A. On [redacted] at 10:40 am, during observation of R #2's medication basket, revealed that: 1. The following medications listed on R #2's [redacted] through [redacted] Medication Administration Record (MAR) was not found in R #2's medication basket: a. [redacted] B. On [redacted] at 10:40 am, during observation of R #4's medication basket revealed that: 1. The followin [redacted] MAR were not found in R #4's medication basket. a. [redacted]	A 034		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	4029	A. BUILDING: _____ B. WING _____	C 06/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALBUQUERQUE UPTOWN ASSISTED LIVING, INC	7611 INDIAN SCHOOL RD NE ALBUQUERQUE, NM 87110

(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 034	Continued From page 26 C. On 06/06/23 at 11:15 am, during an interview with the Administrator, she confirmed that the above medications for R #s 2 and 4 were missing from their medication baskets.	A 034		
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. 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.	A 063		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	4029	A. BUILDING: _____ B. WING _____	C 06/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALBUQUERQUE UPTOWN ASSISTED LIVING, INC	7611 INDIAN SCHOOL RD NE ALBUQUERQUE, NM 87110

(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 063	Continued From page 27 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 22 (R #s 1-22) residents identified on the census provided by the Owner on 06/05/23, staff 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 06/05/23 at 10:00 am, during observation of three of the facility's fire extinguishers (1st floor central hallway, 1st floor Southside hallway, and in the kitchen), it was observed that they had not been inspected monthly as recommended by the manufacturer. B. On 06/05/23 at 10:05 am, during an interview with the Owner, she confirmed that the 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	A 065		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	4029	A. BUILDING: _____ B. WING _____	C 06/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALBUQUERQUE UPTOWN ASSISTED LIVING, INC	7611 INDIAN SCHOOL RD NE ALBUQUERQUE, NM 87110

(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 065	Continued From page 28 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] This REQUIREMENT is not met as evidenced by: 7.8.2.65 B (5) Based on record review and interview, the facility failed to ensure that fire drills conducted monthly included the evacuation time in total minutes. This deficient practice could likely result in the 22 (R #s 1-22) residents identified on the census, provided by the Owner on 06/05/23, to be at risk of harm, injury, or death if a fire were to occur and the Direct Care Staff (DCS) do not know how to safely and promptly evacuate the residents from the building. The findings are: A. Record review of the facility's fire drill records for the months of March 2023, April 2023, and May 2023 all revealed no documentation of the evacuation time in total minutes.	A 065		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	4029	A. BUILDING: _____ B. WING _____	C 06/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALBUQUERQUE UPTOWN ASSISTED LIVING, INC	7611 INDIAN SCHOOL RD NE ALBUQUERQUE, NM 87110

(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 065	Continued From page 29 B. On 06/05/23 at 10:40 am, during an interview with the Owner, she confirmed that the facility fire drill records for the months of March 2023, April 2023, and May 2023 did not include documentation of the evacuation time in total minutes.	A 065		
A 069	7 NMAC 8.2.69 Memory Care Units MEMORY CARE UNITS: An assisted living facility that provides a memory care unit to serve residents with dementia shall comply with the provisions of subsection A-J below in addition to the rules applicable to all assisted living facilities, 7.8.2 NMAC. A. Additional definitions: The following definitions, in addition to those in 7.8.2.7 NMAC, shall apply. (1) " Alzheimer ' s " means a brain disorder that destroys brain cells, causing problems with memory, thinking and behavior that are severe enough to affect work, lifelong hobbies or social life. Alzheimer ' s gets progressively worse and is fatal. (2) " Care coordination agreement requirement " means a written document that outlines the care and services that are provided by other outside agencies for assisted living residents that require additional care and services. (3) " Dementia " means loss of memory and other mental abilities severe enough to interfere with daily life. It is caused by changes in the brain. (4) " Memory care unit " means an assisted living facility or part of or an assisted living facility that provides added security, enhanced programming and staffing appropriate for residents with a diagnosis of dementia, Alzheimer ' s disease or other related disorders causing memory impairments and for residents whose	A 069		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	4029	A. BUILDING: _____ B. WING _____	C 06/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALBUQUERQUE UPTOWN ASSISTED LIVING, INC	7611 INDIAN SCHOOL RD NE ALBUQUERQUE, NM 87110

(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 069	Continued From page 30	A 069		

functional needs require a specialized program.
(5) " Secured environment " means locked (secured/monitored) doors/fences that restrict access to the public way for residents who require a secure unit.
B. Care coordination requirement. An assisted living facility that accepts residents with memory issues shall determine which additional services and care requirements are relevant to the resident and disease process.
(1) The medical diagnosis and ISP shall be utilized in the determination of the need for additional services.
(2) The assisted living facility shall ensure the coordination of services and shall have evidence of an agreement of care coordination for all services provided in the facility by an outside health care provider.
C. Employee training. In addition to the training requirements for all assisted living facilities, pursuant to 7.8.2.17 NMAC, all employees assisting in providing care for memory unit residents shall have a minimum of twelve (12) hours of training per year related to dementia, Alzheimer ' s disease, or other pertinent information.
D. Individual service plan (ISP). An assisted living facility that admits memory care unit residents shall create an ISP in coordination with the resident ' s primary care practitioner, in compliance with the requirements outlined in " Individual Service Plan, " 7.8.2.26 NMAC, pursuant to a team meeting as described in " Exceptions to admission, readmission and retention, " Subsection C of 7.8.2.20 NMAC, and which ensures the following criteria:
(1) identification of the resident's needs specific to the memory care unit and the services that are provided; each memory unit resident shall receive

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	4029	A. BUILDING: _____ B. WING _____	C 06/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALBUQUERQUE UPTOWN ASSISTED LIVING, INC	7611 INDIAN SCHOOL RD NE ALBUQUERQUE, NM 87110

(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 069	Continued From page 31	A 069		

the services necessary to meet the individual resident ' s needs;
(2) 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.
E. Assessments and reevaluations.
(1) An assessment shall be completed by a registered nurse or a physician extender within fifteen (15) days prior to admission. When emergency placement is warranted the fifteen (15) day assessment shall be waived and the assessment shall be completed within five (5) days after admission.
(a) The resident shall have a medical evaluation and documentation by a physician, physician's assistant or a nurse practitioner within six (6) months of admission.
(b) The pre-admission assessment shall include written findings, an evaluation of less restrictive alternatives and the basis for the admission to the secured environment. The written documentation shall include a diagnosis from the resident's PCP of Alzheimer's disease or other dementia and the need for the resident to reside in a memory care unit.
(c) Only those residents who require a secured environment placement or whose needs can be met by the facility, as determined by the assessment prior to admission or on review of the individual service plan (ISP), shall be

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	4029	A. BUILDING: _____ B. WING _____	C 06/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALBUQUERQUE UPTOWN ASSISTED LIVING, INC	7611 INDIAN SCHOOL RD NE ALBUQUERQUE, NM 87110

(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 069	Continued From page 32	A 069		

admitted.
(2) A re-evaluation must be completed every six (6) months and when there is a significant change in the medical or physical condition of the resident that warrants intervention or different care needs, or when the resident becomes a danger to self or others, to determine whether the resident ' s stay in the assisted living facility memory care unit is still appropriate.
F. Documentation in the resident ' s record. In addition to the required documentation pursuant to 7.8.2.21 NMAC, the following information shall be documented in the resident ' s record:
(1) the physician ' s diagnosis for admission to a secure environment or a memory care unit;
(2) the pre-admission assessment; and
(3) the re-evaluation(s).
G. Secured environment.
(1) Memory care unit residents may require a secure environment for their safety. A secured environment is any locked (secured/monitored) area in which doors and fences restrict access to the public way. These include but are not limited to:
(a) double alarm systems;
(b) gates connected to the fire alarm; and
(c) tab alarms for residents at risk for elopement.
(2) In addition to the interior common areas required by this rule, the facility shall provide a safe and secure outdoor area for the year round use by the residents.
(a) Fencing or other enclosures shall prevent elopement and protect the safety and security of the residents.
(b) Residents shall be able to independently access the outdoor areas.
(3) Locked areas shall have an access code or key which facility employees shall have available on their person or on the locking unit itself at all

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	4029	A. BUILDING: _____ B. WING _____	C 06/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALBUQUERQUE UPTOWN ASSISTED LIVING, INC	7611 INDIAN SCHOOL RD NE ALBUQUERQUE, NM 87110

(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 069	Continued From page 33 times. H. Resident rights. In addition to the requirements pursuant to 7.8.2.32 NMAC, the following shall apply: (1) the resident's rights may be limited as required by their condition and as identified in the ISP; (2) the resident who believes that he or she has been inappropriately admitted to the secured environment may request the facility in contact the resident ' s legal guardian, or an advocate such as the ombudsman or the primary care practitioner; upon request, the facility shall assist the resident in making such contact. I. Disclosure to residents. A facility that operates a secured environment shall disclose to the resident and the resident ' s legal representative, if applicable and prior to the resident ' s admission to the facility, that the facility operates a secured environment. (1) The disclosure shall include information about the types of resident diagnosis or behaviors that the facility provides services for and for which the staff are trained to provide care for. (2) The disclosure shall include information about the care, services and the type of secured environment that the facility and trained staff provide. J. Staffing. The facility shall provide the sufficient number of trained staff members to meet the additional needs of the residents in the secured environment. There must be at least one (1) trained staff member awake and in attendance in the secured environment at all times. [7.8.2.69 NMAC - N, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.69 G (2) (b)	A 069		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	4029	A. BUILDING: _____ B. WING _____	C 06/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALBUQUERQUE UPTOWN ASSISTED LIVING, INC	7611 INDIAN SCHOOL RD NE ALBUQUERQUE, NM 87110

(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 069	Continued From page 34 Based on observation and interview, the facility failed to ensure that residents who have Alzheimer's or dementia (memory loss) could independently access the [redacted] This deficient practice could likely result in the the [redacted] residents identified on the census provided by the Owner on [redacted] to not be able to enjoy the outdoor areas when they want to. The findings are: A. On 06/05/23 at 9:25 am, during observation of the facility's [redacted] outdoor courtyard area available for use by all (Assisted Living and Memory Care) residents, it was observed that a code was needed to exit and enter the door to the courtyard. This prevented residents with Alzheimer's or dementia from being able to independently access the courtyard. B. On 06/05/23 at 9:35 am, during an interview, the Owner confirmed that the door to the facility's Northside outdoor courtyard area requires a code to exit/enter and that the residents were not able to independently access the courtyard.	A 069	Pad lock has been removed 6-2-23 and disarmed. Door opens freely for residents to come in and out as they wish. Door is locked after 5pm. Due to homeless activity in the area - See attached staff is responsible on their shift to monitor door. Must be unlocked @ 6am and locked @ 5pm	