Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	4028	A. BUILDING: _____ B. WING _____	C 08/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORNINGSTAR OF ALBUQUERQUE	8051 PALOMAS AVE NE ALBUQUERQUE, NM 87109

(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
8 000	Initial Comments The following deficiencies were cited during a Complaint survey completed on 08/06/25 for the state requirements of NMAC 8.730.14, Regulations for Assisted Living for Adults. Census: 50 Assisted Living, 18 Memory Care Complaint intake NM[redacted] was investigated and deficiencies were not cited.	8 000		
8 032	8 NMAC 370.14.32 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 8.370.9 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 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 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 8.370.9 NMAC; and	8 032	Tag A032 – 8 NMAC 370.14.32 Reporting of Incidents Plan of Correction 1. Identification of Other Residents/Staff Potentially Affected: The facility acknowledges that untimely reporting of incidents and delayed investigations could pose a risk to all residents and staff. To ensure no other residents were affected, a comprehensive review of all incident reports from January 1, 2024 through August 25, 2025 was conducted. Besides the incidents identified in the survey, no additional unreported or late-reported incidents were found. 2. Corrective Measures/Systemic Changes Implemented: Continued on next page.	Compliance Date: 09/2/2025

Division of Health Improvement
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE [signature] TITLE ED (X6) DATE 8/27/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	4028	A. BUILDING: _____ B. WING _____	C 08/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORNINGSTAR OF ALBUQUERQUE	8051 PALOMAS AVE NE ALBUQUERQUE, NM 87109

(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
8 032	Continued From page 1 (3) plans for further actions in response to the incident. [8.370.14.32 NMAC - N, 7/1/2024] This REQUIREMENT is not met as evidenced by: 8.370.14.32 A (1) B REPORTING OF INCIDENTS: A. The facility shall ensure (to make certain that something shall occur or be the case) that all suspected cases or known incidents of resident abuse, neglect or exploitation are reported in accordance with 8.370.9 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. (3) All licensed health care facilities shall ensure that the reporter with direct knowledge of an incident has immediate access to the bureau incident report form to allow the reporter to respond to, report, and document incidents in a timely and accurate manner. 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. Based on record review and interview, the facility failed to ensure for 1 (R #2) of 1 (R #2) resident whose incident reports were reviewed for	8 032	• On September 2, 2025, the facility will conduct mandatory onsite training with the Division of Health Improvement (DHI) for leadership and direct care staff regarding reporting requirements, the 24-hour notification timeline, and completion of investigations within five business days. • Effective immediately, all incidents will be entered onto a Daily Incident Tracking Log. This log will be reviewed every morning by the Executive Director or Designee and the Wellness Director to ensure that any reportable incidents are submitted to the Licensing Authority within the required 24-hour window (or by the next business day if a weekend or holiday). • All investigations will be completed within five business days using the state-approved form. A copy of the investigation and proof of submission to the Licensing Authority will be retained in the facility's records. • A written policy addendum has been issued stating that internal investigations must not delay external reporting. Continued on next page.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	4028	A. BUILDING: _____ B. WING _____	C 08/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORNINGSTAR OF ALBUQUERQUE	8051 PALOMAS AVE NE ALBUQUERQUE, NM 87109

(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
8 032	Continued From page 2 compliance that incidents were reported within twenty-four (24) hours and an investigation was conducted within five (5) business days and reported to the Licensing Authority (LA). This deficient practice could impede (delay or prevent) regulatory oversight and hinder (create difficulties resulting in delay) the identification of care trends or patterns that may affect resident outcomes. The findings are: A. Record review of the facility's observation report dated 03/05/24, revealed R[redacted] had an injury of unknown origin and was sent to the Emergency Room (ER) for further evaluation. The incident was not reported to the LA within twenty-four (24) hours and an investigation was not conducted within five (5) business days and reported to the LA. B. Record review of R[redacted] incident report dated 04/23/24, revealed R[redacted] had an unwitnessed fall with injury and the incident was not reported timely to the LA within twenty-four (24) hours but was reported on 04/25/24. C. Record review of R[redacted] incident report dated 05/08/24, revealed R[redacted] had an unwitnessed fall with injury and the incident was not reported to the LA within twenty-four (24) hours and an investigation was not conducted within five (5) business days and reported to the LA. D. Record review of R[redacted]s incident report dated 11/22/24, revealed R[redacted] had an injury of unknown origin and the incident was not reported to the LA within twenty-four (24) hours and an investigation was not conducted within five (5) business days	8 032	• 3. Monitoring for Ongoing Compliance: • The Executive Director or Designee will conduct weekly audits of the Daily Incident Tracking Log and incident reports to verify compliance with timelines. • Audit results will be presented during monthly QAPI (Quality Assurance and Performance Improvement) meetings to track compliance trends. • Any staff deviations from policy will result in immediate re-education and corrective coaching. • 4. Responsibility for Compliance: • The Executive Director or Designee will be responsible for ensuring compliance with reporting and investigation requirements, supported by the Wellness Director for daily oversight. • 5. Completion Date: • All corrective actions—including retrospective review, staff training, policy updates, and implementation of the tracking log—will be completed by September 2, 2025, which serves as the final completion date for this citation.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	4028	A. BUILDING: _____ B. WING _____	C 08/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORNINGSTAR OF ALBUQUERQUE	8051 PALOMAS AVE NE ALBUQUERQUE, NM 87109

(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
8 032	Continued From page 3 and reported to the LA. E. On 08/06/25 at 4:20 PM, during an interview, the Executive Director confirmed R[redacted] incidents on 03/05/24 and 11/22/24 were not reported to the LA within twenty-four (24) hours and investigations were not conducted within five (5) business days and reported to the LA and the incident dated 04/23/24 was not reported timely. F. On 08/06/25 at 5:10 PM, during an interview, the Executive Director confirmed R[redacted] incident on 05/08/24 was not reported to the LA within twenty-four (24) hours and an investigation was not conducted within five (5) business days and reported to the LA.	8 032		
8 038	8 NMAC 370.14.38 Housekeeping Services The facility shall maintain the interior and exterior of the facility in a safe, clean, orderly and attractive manner. The facility shall be free from offensive odors, safety hazards, insects and rodents and accumulations of dirt, rubbish and dust. A. All common living areas and all bathrooms shall be cleaned as often as necessary to maintain a clean and sanitary environment. B. Combustibles such as cleaning rags or flammable substances shall be stored in closed metal containers in approved areas that provide adequate ventilation. Combustibles shall be stored away from the food preparation areas and away from the resident rooms. C. Poisonous or flammable substances shall not be stored in residential areas, food preparation areas or food storage areas. If hazardous chemicals are stored on the property, material safety data sheets shall be maintained and stored	8 038	Tag A038 – 8 NMAC 370.14.38 Housekeeping Services Plan of Correction 1. Identification of Other Residents/Staff Potentially Affected: The Facility recognizes that the unsecured housekeeping cart observed on August 5, 2025 created the potential for all residents, visitors, and staff to be affected, not just those in the immediate area of Room #236. To ensure no other unsafe conditions existed, a comprehensive inspection of all housekeeping carts, supply closets, and storage areas throughout the building was conducted on August 25, 2025. No additional unsecured chemicals were identified at that time. Continued on next page.	Compliance Date: 08/28/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	4028	A. BUILDING: _____ B. WING _____	C 08/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORNINGSTAR OF ALBUQUERQUE	8051 PALOMAS AVE NE ALBUQUERQUE, NM 87109

(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
8 038	Continued From page 4 in the same area as the chemicals, pursuant to state environment department requirements, 11.5.2.9 NMAC. [8.370.14.38 NMAC - N, 7/1/2024] This REQUIREMENT is not met as evidenced by: 8.370.14.38 C Based on observation and interview, the facility failed to ensure poisonous or flammable chemicals were stored in a secured area and not in residential areas. This deficient practice could likely result in residents becoming ill if they ingest (take food, drink, or another substance in the body by swallowing or absorbing it) the chemicals. The findings are: A. On 08/05/25 at 9:48 AM, during observation of the 2nd floor of the facility during a tour of the facility, a housekeeping cart was stored next to room #236, with the cabinets unlocked, unsecured and open with the following chemicals inside: 1. One (1) 4 ounce (oz) bottle of lemon essential oil. 2. One (1) 6.35 oz spray can of air freshener. 3. One (1) 32 oz spray bottle of germicidal cleaner and bleach. 4. One (1) 6.25 oz spray can of odor neutralizer and natural oils. 5. One (1) gallon (gal) of germicidal ultra bleach. 6. One (1) 32 oz spray bottle of foodservice surface sanitizer. 7. One (1) quart (qt) of lemon furniture polish. 8. One (1) 16 oz spray can of stainless steel	8 038	2. Corrective Measures/Systemic Changes Implemented: • On August 25, 2025, the Facility purchased locking mechanisms and new housekeeping carts equipped with locking compartments for the secure storage of all chemicals. • All staff received an in-service on August 25, 2025 regarding: ◦ Proper storage of chemicals, flammables, and hazardous substances. ◦ The requirement to keep carts locked and unattended chemicals secured at all times. ◦ Immediate reporting protocols if a cart is found unsecured. • Material Safety Data Sheets (MSDS) were reviewed and updated to ensure compliance, and copies remain stored in designated areas. • Signage was placed in all storage areas reminding staff of the policy: "Chemicals must never be left unsecured." 3. Monitoring for Ongoing Compliance: • The Maintenance Director will conduct weekly spot checks of housekeeping carts and chemical storage areas to confirm chemicals remain locked and secured. Continued on next page.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	4028	A. BUILDING: _____ B. WING _____	C 08/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORNINGSTAR OF ALBUQUERQUE	8051 PALOMAS AVE NE ALBUQUERQUE, NM 87109

(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
8 038	Continued From page 5 polish. 9. One (1) 24 oz spray bottle of natural multipest elimination (bug spray). 10. One (1) 32 oz spray bottle of fabric refresher. B. On 08/05/25 at 9:57 AM, during an interview, the Senior Wellness Director confirmed the unsecured chemicals in the housekeeping cart.	8 038	• Results of these checks will be documented on a Chemical Storage Audit Log. • The Maintenance Director will review the audit log monthly and report findings at the facility's Quality Assurance and Performance Improvement (QAPI) Committee meetings. • Education on chemical storage and cart security will be reinforced during monthly All Staff Meetings and with all new employee orientation. 4. Responsibility for Compliance: The Maintenance Director is responsible for monitoring compliance with chemical storage requirements. Oversight of continued compliance will be reviewed by the Executive Director during QAPI meetings.	