STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	4047	A. BUILDING: _____ B. WING _____	C 10/03/2023

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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 000	Initial Comments The following deficiencies were cited during a Complaint survey completed on 10/03/23 for the state requirements of 7.8.2 NMAC Regulations for Assisted Living Facilities for Adults. Complaint Intake ID #NM[redacted] was investigated with deficiencies cited. Complaint Intake ID #NM[redacted] was investigated with deficiencies cited. Census: 84 (60 ALF, 24 MCU) ABBREVIATIONS/ACRONYM DEFINITIONS: ADL: Activities of Daily Living AL: Assisted Living ALF: Assisted Living Facility Anus: The opening at the end of the alimentary canal through which solid waste matter leaves the body. BM: Bowel movement/feces cm: Centimeter Coccyx: Tailbone; the final segment of the vertebral column in all apes and analogous structures in certain other mammals such as horses. DCS: Direct Care Staff IR: Incident Report ISP: Individual Service Plan LPN: Licensed Practical Nurse MC: Memory Care MCU: Memory Care Unit NM: New Mexico NMAC: New Mexico Administrative Code NMDOH - DHI: New Mexico Department of Health - Division of Health Improvement P/P: Policy and Procedure PE: Physician Extender POA: Power of Attorney	A 000		

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R: Resident
RCC: Resident Care Coordinator
RN: Registered Nurse

PRESSURE SORE STAGES:

Pressure Sore: Ulcers that occur on the skin surface due to prolonged pressure, like lying in bed without movement or sitting in a wheelchair for prolonged periods.

Stage I: Intact skin with localized, non-blanchable erythema (redness of the skin and/or mucous membranes) over a bony prominence. The area may be painful, firm or soft and warmer/cooler compared to surrounding tissue. The patient is at risk for further tissue damage if pressure is not relieved.
Stage II: A partial thickness wound presenting as a shallow, open ulcer with a red/pink wound bed. It may also present as an intact or open/ruptured serum-filled or serosanguinous-filled blister. Slough may be present but does not obscure the depth of tissue loss.
Stage III: A full-thickness wound (subcutaneous tissue may be visible but bone, tendon and muscle are not exposed). It may include undermining or sinus tracks. Slough or eschar may be present but do not obscure the depth of tissue loss.
Stage IV: A full-thickness wound with exposed bone, tendon or muscle often includes unermining and/or sinus tracks. Slough or eschar may be present on some parts of the wound bed but does not obscure the depth of tissue loss.
Unstageable: A wound in which the wound bed is covered by sufficient slough and/or eschar to preclude staging.

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A 019	Continued From page 2	A 019	Stafing ratios have been increased on all shifts to meet state minimum requirements. RCC, RN, and ED will continue to monitor staffing needs and schedule each week and will utilize PRN care staff and agency as needed to ensure compliance with NMAC.	7/1/24
A 019	7 NMAC 8.2.19 Staffing Ratios STAFFING RATIOS: The following staffing levels are the minimum requirements. A. The facility shall employ the sufficient number of staff to provide the basic care, resident assistance and the required supervision based on the assessment of the residents ' needs. (1) During resident waking hours, facilities shall have at least one (1) direct care staff person on duty and awake at all times for each fifteen (15) residents. (2) During resident sleeping hours, facilities with fifteen (15) or fewer residents shall have at least one (1) direct care staff person on duty, awake and responsible for the care and supervision of the residents. (3) During resident sleeping hours, facilities with sixteen (16) to thirty (30) residents shall have at least one (1) direct care staff person on duty and awake at all times and at least one (1) additional staff person available on the premises. (4) During resident sleeping hours, facilities with thirty-one (31) to sixty (60) residents shall have at least two (2) direct care staff persons on duty and awake at all times and at least one (1) additional staff person immediately available on the premises. (5) During resident sleeping hours, facilities with more than sixty-one (61) residents shall have at least three (3) direct care staff persons on duty and awake at all times and one (1) additional staff person immediately available on the premises for each additional thirty (30) residents or fraction thereof in the facility. B. Upon request of the department, the facility shall provide the staffing ratios per each twenty-four (24) hour day for the past thirty (30) days.	A 019		

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A 019	Continued From page 3 [7.8.2.19 NMAC - Rp, 7.8.2.18 NMAC, 01/15/2010]	A 019		

This REQUIREMENT is not met as evidenced by:
7.8.2.19 A

This is a repeat deficiency from survey dated 10/26/22 and 02/08/23.

Based on observation, and interview, the facility failed to ensure that there was enough Direct Care Staff (DCS) on duty and available at all times, in the facility to:

1. Meet the basic care, assistance, and supervision of all the residents' needs.
2. Provide the required supervision and assistance for all residents who meet their higher level of care based on the specific needs (those residents requiring a two (2) or three (3) person assistance for transfers).

This deficient practice could likely result in the 84 (R #s 1-84) residents identified on the census, provided by the Executive Director on 09/19/23, to be at risk of harm, injury, or death, if there is not adequate staffing available to provide needed care/services and supervision.

The findings are:

A. On 09/20/23 at 9:58 am, during an interview, R #2's POA #2 stated that R #2 is a [redacted] but the facility uses only one (1) DCS to assist because they are short-staffed.

B. On 09/20/23 at 11:33 am, during an interview, DCS #10 stated that one of the reasons for

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A 019	Continued From page 4	A 019		

resigning on 08/30/23 was consistent short-staffing and reported the following:

1. On Friday night, 08/25/23, she worked alone in the AL unit, and the call pagers were behind almost 2 hours.
2. She (DCS #10) tried contacting her Supervisor, DCS #3, to ask for more coverage, but DCS #3 did not answer.
3. She again worked alone on the Saturday morning shift (08/26/23) for about 3.5 hours.
4. All residents were in jeopardy because they did not have enough staff that morning.

C. On 09/21/23 at 11:00 am, during an interview, DCS #5 confirmed that there were not enough staff on duty at the facility and stated that for about sixty (60) people, two (2) DCS aren't enough.

D. On 09/27/23 at 9:24 am, during an observation of R #1's room [redacted] breakfast was on a table approximately 10 feet from [redacted] bed and [redacted] is [redacted] The food appeared to be cold and to have been sitting there for a while. There were trays with old sandwiches near the microwave and they were crawling with ants.

E. On 09/27/23 at 11:11 am, during an observation of R #1's room, the following was observed:

1. Trays with old sandwiches were still sitting on a table and crawling with ants.
2. DCS #4 was clearing up the oatmeal after feeding R #1 [redacted] breakfast.

F. On 09/27/23 at 11:11 am, during an interview with DCS #4, she stated that they delivered R #1's food at 8:00 am, but they were unable to feed [redacted] breakfast until 11:00 am, because they were short-staffed.

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A 019	Continued From page 5 G. On 10/03/23 at 3:00 pm, during an interview, the Executive Director confirmed that the facility was often short-staffed. H. On 10/12/23 at 4:48 pm, during an interview, DCS #3 confirmed that they usually only have two (2) staff working during the graveyard shift, and for the past few months, they have been short-staffed in AL.	A 019		
A 024	7 NMAC 8.2.24 Assistance with Daily Living ASSISTANCE WITH DAILY LIVING: The facility shall supervise and assist the residents, as necessary, with health, hygiene and grooming needs, to include but not limited to the following: A. eating; B. dressing; C. oral hygiene; D. bathing; E. grooming; F. mobility; and G. toileting. [7.8.2.24 NMAC - Rp, 7.8.2.25 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.24 A Based on record review and interview, the facility failed to ensure that 1 (R[redacted] of 9 (R #s [redacted] residents whose Assisted with Daily Living Activities (ADLs) records were reviewed for compliance and received assistance with [redacted] as scheduled.	A 024	ISP's will be updated by RN after significant change of condition is reported. Changes to ISP's will be documented in the Point Click Care (PCC) Communication Log for each shift to ensure that DCS is informed of any changes to resident ISP's. 24-hour report will be monitored by RCC, RN, and ED during clinical stand-up each weekday morning to ensure all Point of Care (POC) tasks have been completed for each shift.	7/1/24

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A 024	Continued From page 6	A 024		

This deficient practice could likely result in residents to be at risk of becoming ill if proper nutrition is not maintained because they were not assisted with [redacted] as scheduled. The findings are:

A. On 09/27/23 at 8:10 am, during an interview, the facility RN reported that R [redacted] has been refusing breakfast and skipping other meals. The facility RN is concerned about R [redacted] nutrition because [redacted] won't heal unless [redacted] has proper nutrition.

B. On 09/27/23 at 9:27 am, during observation of R #1's room:
1. [redacted] breakfast was placed beyond [redacted] reach.
2. Breakfast was left out uncovered, and R [redacted] was not assisted with being fed until 11:00 am.

C. On 09/27/23 at 9:27 am, during an interview, DCS #4 confirmed that R [redacted] requires assistance with eating due to [redacted] does not have the ability to feed [redacted]

D. Record review of R [redacted] Significant Change of Condition form date[redacted]23 revealed:
1. R [redacted] requires assistance with [redacted]
2. Has limitations in [redacted] and both feet.

E. On 09/27/23 at 4:15 pm, during an interview, the Executive Director, he confirmed that R [redacted]
1. Was not provided assistance with [redacted] breakfast until 11:00 am on 09/27/23.
2. R #1 requires assistance with [redacted]

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A 026	Continued From page 7 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	RN will ensure weekly skin checks are completed and skin condition log is completed for each resident documenting who is managing the wound care (hospice, facility nurse, home health). Change of condition meeting will be held when there is a change or progression of wound. ISP will be reviewed and updated to reflect any significant changes in the resident's health. Skin logs will reviewed during Clinical Stand-up each weekday morning.	7/1/24

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A 026	Continued From page 8 those authorized for PRN usage. [7.8.2.26 NMAC - Rp, 7.8.2.26 NMAC, 01/15/2010]	A 026		

This REQUIREMENT is not met as evidenced by:
7.8.2.26 A (3)

This is a repeat deficiency for survey dated 10/26/22.

Based on record review and interview, the facility failed to ensure for 1 (R[redacted] of 1 (R[redacted] resident whose Individual Service Plan (ISP) was 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.

This deficient practice could likely result in the residents not receiving appropriate care/services if the ISPs are not current.

The findings are:

A. Record review of R[redacted]s (admission date: [redacted]) resident file revealed no documentation that the ISP dated [redacted]/23 was reviewed and or revised when there was a significant change in the resident's health status for the [redacted]

B. On 09/27/23 at 8:10 am, during an interview, the facility RN confirmed the following:
1. On 03/20/23, when R[redacted] was admitted, [redacted]

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A 026	Continued From page 9 had no [redacted] body. 2. On 07/06/23, R[redacted] had two separate [redacted] 3. On 07/15/23, R[redacted] had two separate [redacted] 4. On 08/12/23, R[redacted] had one [redacted] 5. Over the past three weeks, the [redacted] 6. On [redacted]23 [redacted] notes indicated that [redacted] 7. The facility never had a change of condition meeting from each stage progression/transition. 8. R[redacted] has been refusing breakfast and skipping other meals, and the RN is concerned about [redacted] nutrition because [redacted] won't heal unless [redacted] has proper nutrition. 9. R[redacted] ISP had never been reviewed and/or updated when a significant change (developed [redacted] nutrition) in the resident's health status.	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	Facility will report any accusations of abuse or neglect reported by a resident or staff members to Licensing Authority within 24 hours of incident or on the next business day. An IR will be created and a thorough internal investigation will be conducted. Licensing Authority will be sent a copy of the follow-up investigation within 5 days of the reported incident.	7/1/24

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A 032	Continued From page 10 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 (1-3) This is a repeat deficiency for survey dated 10/26/22. 7.1.13 INCIDENT REPORTING, INTAKE, PROCESSING AND TRAINING REQUIREMENTS Refer to 7.1.13.7 W. 8 B. (2)	A 032		

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A 032	Continued From page 11 W. " Reportable incident " means possible abuse, neglect, exploitation, injuries of unknown origin, and other events, including but not limited to falls which cause injury, unexpected death, elopement, medication error, which causes or is likely to cause harm, failure to follow a doctor's order or an ISP or any other incident which may evidence abuse, neglect, or exploitation. B. (2) Division incident report form and notification by licensed health care facilities: The licensed health care facility shall report incidents utilizing the division's incident report form consistent with the requirements of the division's incident management system guide and CMS regulations as applicable. The licensed health care facility shall ensure that all incident report forms alleging abuse, neglect, exploitation, injuries of unknown origin or other reportable incidents are submitted by a reporter with direct knowledge of an incident, are completed on the bureau's incident report form and received by the division within twenty-four (24) hours of an incident or allegation of an incident or the next business day if the incident occurs on a weekend or a holiday. The licensed health care facility shall ensure that the reporter with the most direct knowledge of the incident assists with the preparation of the incident report form. C. All licensed health care facilities shall conduct a complete investigation and report the actions taken and conclusions reached by the facility within five (5) days of discovery of the incident. [7.1.13.10 NMAC - Rp, 7.1.13.11 NMAC, 7/1/14] Based on record review and interview, the facility failed to ensure for 1 (R #2) of 1(R #2) resident whose Internal Incident Report was reviewed for compliance that all suspected cases or known	A 032		

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A 032	Continued From page 12	A 032		

incidents of resident abuse, neglect, exploitation, or unusual occurrences which has or could threaten the health, safety, or welfare of the residents and staff were:

1. Reported to the Licensing Authority within twenty-four (24) hours or by the next business day if it is a weekend or a holiday.

2. Investigated internally by the facility and submitted an Investigation/Follow-Up Report to the Licensing Authority within five (5) business days from the date the incident 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 the Executive Director's (ED's) written statement dated [redacted]23 revealed:

1. He interviewed R #2 in his office and asked [redacted] what happened in the incident with DCS #1. R #2 stated that [redacted](R #2) had a dirty brief, DCS #1 and DCS #4 came in to change [redacted] wasn't ready to do so yet, s[redacted] asked that they come back later.

2. They came back in 5-10 minutes, and when they went to change [redacted] the "stool was stuck to my butt," so they had to rub a little hard to get [redacted] cleaned up.

3. R #2 said that was all that happened, and it was not hurting [redacted]

B. Record Review of DCS #1's statement taken by MCU Administrator 09/13/23 at 10:55 am, stated that:

1. On 08/18/23, in the morning, DCS #4 and DCS #1 were getting residents up, and then they

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went into R #2's room together.

2. R #2 stated that [redacted] had "shit [redacted] so. DCS #1 put on gloves, and DCS #4 handed [redacted] the wipes.

3. While DCS #1 was getting [redacted] cleaned up, [redacted] R #2) had dry BM (bowel movement/poop) that had to be cleaned off. During that time, R #2 said, "Oww," and DCS #1 apologized and told [redacted] that she wasn't trying to hurt [redacted] she was just trying to ge[redacted]eaned up.

4. DCS #1 got R #2 dressed for breakfast and took [redacted] downstairs.

C. Record review of R #2's Witness Statement dated 09/13/23 at 1:50 pm, taken by MCU Administrator, stated:

1. DCS #1 left for a little bit and told R #2 to get ready. Then DCS #1 came back in and got angry because R #2 wasn't ready yet.

2. R #2 didn't have clothes on yet, and DCS #1 got angry and took out the soap and shoved it up R #2's butt.

3. DCS #1 said, "Oh wow, you are so dirty back there."

D. Record review of DCS #1's Witness Statement dated 09/25/23 statement stated:

1. R #2 said [redacted]ed "shit[redacted]pants."

2. DCS #1 noticed that R #2's feces were dry and advised DCS #4 to take a look s[redacted] had a witness.

3. DCS #1 wiped R #2 up when she realized that part of [redacted]eces was stuck i[redacted]anus (butt) and that it would need to be pulled out.

4. R #2 immediately screamed, and DCS #1 advised that the feces was stuck and that she was simply trying to remove it.

5. Since the incident, DCS #1 has had no contact with R #2, and DCS #1 will not go near [redacted] apartment for any reason.

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A 032	Continued From page 14 E. On 09/27/23 at 4:15 pm, during an interview with the Executive Director, he confirmed that regarding R #2's allegation of being sexually abused by DCS #1, the facility failed to: 1. Report this incident to the Licensing Authority within 24 hours or the next business day if it is a holiday or weekend. 2. Conduct a thorough internal investigation and submit a follow-up investigation report to the Licensing Authority within five (5) days from the date the incident occurred.	A 032		
A 033	7 NMAC 8.2.33 Resident Rights RESIDENT RIGHTS: All licensed facilities shall understand, protect and respect the rights of all residents. A. Prior to admission to a facility, a resident and legal representative shall be given a written description of the legal rights of the resident, translated into another language, if necessary, to meet the resident ' s understanding. B. If the resident has no legal representative and is incapable of understanding his or her legal rights, a written copy of the resident's legal rights shall be provided to the most significant responsible party in the following order: (1) the resident's spouse; (2) significant other; (3) any of the resident's adult children; (4) the resident's parents; (5) any relative the resident has lived with for six or more months before admission; (6) a person who has been caring for, or paying benefits on behalf of the resident; (7) a placing agency; (8) resident advocate; or (9) the ombudsman.	A 033	ED and RN will notify families/POA's whenever there is a report of abuse or neglect to offer them the opportunity to be present for resident interviews to investigate any potential reports of abuse or neglect. Facility will ensure the resident's rights to communicate privately and freely with any person regarding allegations of abuse or neglect. Wound care will be performed by the facility RN, Hospice LN, or qualified medical professional. Wound care will not be assigned to DCS. All IR's will be reviewed each weekday morning during Clinical Stand-up.	7/1/24

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A 033	Continued From page 15 C. The resident rights shall be posted in a conspicuous public place in the facility and shall include the telephone numbers for the incident management hotline and for the state ombudsman program. D. To protect resident rights, the facility shall: (1) treat all residents with courtesy, respect, dignity and compassion; (2) not discriminate in admission or services based on gender, sexual orientation, resident's age, race, religion, physical or mental disability, or nationality; (3) provide residents written information about all services provided by the facility and their costs and give advance written notice of any changes; (4) provide residents with a safe and sanitary living environment; (5) provide humane care for all residents; (6) provide the right to privacy, including privacy during medical examinations, consultations and treatment; (7) protect the confidentiality of the resident ' s medical record; (8) protect the right to personal privacy, including privacy in personal hygiene; privacy during visits with a spouse, family member or other visitor; and privacy in the resident's own room; (9) protect the right to communicate privately and freely with any person, including private telephone conversations and private correspondence; and the right to receive visits from family, friends, lawyers, ombudsmen and community organizations; (10) prohibit the use of any and all physical and chemical restraints; (11) ensure that residents: (a) are free from physical and emotional abuse neglect and misappropriation/or exploitation; (b) are free from financial abuse and	A 033		

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

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and
(q) are protected from unjustified room transfers or discharge.
E. The resident's rights shall not be restricted unless this restriction is for the health and safety of the resident, agreed to by the resident or the resident ' s surrogate decision maker and outlined in the resident ' s individual service plan.
[7.8.2.33 NMAC - Rp, 7.8.2.34 NMAC, 01/15/2010]

This REQUIREMENT is not met as evidenced by:
7.8.2.33 D 9, 11 (a)

This is a repeat deficiency for survey dated 10/26/22.

Based on record review and interview, the facility failed to ensure for [redacted] R #s [redacted] of 2 (R #s [redacted] and [redacted] residents:
1. With [redacted] received needed treatments only by Licenesed Nurses and/or qualified Medical Professionals.
2. Had the right to communicate privately and freely with any person regarding allegations of abuse and/or neglect.

These deficient practices could likely result in the residents to be at risk of emotional, mental, physical harm, injury, or illness if:
1. Resident wound care is being provided by non-licensed staff instead of a Licensed Nurse or Medical professional and fails to provide timely treatment and care for a resident with pressure sores.
2. Residents do not feel comfortable repoting allegaions and/or providing information without

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privacy.

The findings are:

Findings related to R #1

A. Record Review of Complaint Intake # [redacted] received on [redacted]23, revealed the Complainant reported that she was concerned about R #1 and stated the following:

1. R #1 has a tunneling [redacted] on [redacted]

2. Complainant does not believe R #1 is getting the medical care or attention needed to ensure the healing of the bed sore.

B. Record review of R #1's ISP dated [redacted]23 revealed the following:

1. Goal: R [redacted] will show a reduction in size, will show no signs of infection and have minimal drainage.

2. R [redacted]

3. Staff to turn R [redacted] every 2 hours on each shift.

4. Staff to follow protocol/treatment plan.

5. Revision on [redacted]23 stated "Staff to clean [redacted] with each brief change.

C. Record review of R [redacted] facility Monthly Coordination of Care Assessment dated [redacted]23, revealed that R [redacted] was admitted to [redacted] [Name of [redacted] for aditional support for [redacted] and medical care. The resident has a [redacted]

D. Record review of R #[redacted] weekly skin integrity assessment dated [redacted]23 revealed that the [redacted]

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1. 12 cm (centimeters) in length, 4 cm's in width, and 6 cm's in width, and was unstageable.
2. Pink with spots of eschar (a bed sore that has advanced beyond the 1st stages, has broken skin, pontiently allowing bacteria to enter body).
3. Bloody drainage
4. Clean with wound cleanser and Betadine (an antiseptic and disinfectant that is used to treat and prevent infection in wounds and cuts) [redacted] nurse does in depth wound care 2x's weekly.

E. Record review of R[redacted] facility progress notes dated [redacted]23 revealed that R[redacted]

F. On 09/25/23 at 9:58 am, during an interview, DCS #8 she stated the following:
1. R[redacted] had [redacted] and facility RN barely looked at it a week ago. The [redacted] is really deep (2 inches deep) and R[redacted] has had the [redacted] for months now. The [redacted] Med techs write incident reports/vitals when there are [redacted] She (Facility RN) told caregivers/med techs what to do about it then she finally looked at it.
2. The facility RN says they (DCS) have to provid[redacted] cleaner, and pack wound with iodine. She (Facility RN) gives [redacted] irectives with messages and in person.
3. They wipe, clean, and change R[redacted] every 2 hours and they pack it with gauze soaked in iodine.
4. The facility RN answers questions, but she expects DCS to do it all.
5. Med Techs and caregivers both have to

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A 033	Continued From page 20 provide[redacted]ccording to the Nurse. 6. R[redacted] Nurse that comes in to provide[redacted] care as well. 7. Every 2 hours, the DCS rotat[redacted] wipe [redacted]clean [redacted] change [redacted] At the end of every shift, they change dressings. They change the dressings twice a day. G. On 09/27/23 at 8:35 am, during an interview with the facility RN, she confirmed: 1. On[redacted]23, when R[redacted] was admitted[redacted] had no[redacted]n her body. 2. On 07/06/23, R[redacted] had two[redacted] 3. On 07/15/23, R[redacted] had two separate[redacted] 4. On 08/12/23, R[redacted] had one[redacted] [redacted]Are there any records to support the staging of the[redacted] 5. Over the past three weeks (approximate dates[redacted]/23 through[redacted]/23), the[redacted] 6. R[redacted] had been refusing breakfast and skipping other meals. The facility RN was concerned abou[redacted]nutrition becaus[redacted] pressure sores would not heal unles[redacted] has proper nutrition. 7. RN never updated R[redacted] Individual Service Plan (ISP) for the significant change in the resident's health status.[redacted]	A 033		

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H. On 10/03/23 at 9:43 am, during an interview, DCS #11 confirmed:

1. The facility Nurse (on an unknown date/time) instructed DCS #11 (not a Licensed Nurse or medicinal professional) to provide [redacted] care to R[redacted] The [redacted] care consisted [redacted]

2. DCS #11 (on unknown date/time) told the facility Nurse she felt uncomfortable providing [redacted] care to R[redacted]

3. The facility Nurse had an outside agency train (unknown date/time) the DCS who assist residents with the self-administration of their medications on how to provide the [redacted] care.

4. The facility Nurse watched (unknown date/time) the DCS staff perform[redacted] to ensure they knew how to provide[redacted]

5. R[redacted] was black and necrotic (death of tissue) in some areas [redacted]?

I. On 10/04/23 at 8:30 am, during an interview, R[redacted] Nurse stated:

1. That she (R[redacted] nurse) had been working with R[redacted] since [redacted]23, when R[redacted] was approved for [redacted].

2. R[redacted] were already combined and completely necrotic by the time she started working with R[redacted]

3. R[redacted] needed to be treated with Betadine which takes out necrotic (dead or devitalized tissue). It is a process, and it took about two weeks for sloughing (dead skin) to occur. [redacted] nurse) had to get all

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that necrotic tissue out to see what was underneath the [redacted] The [redacted] was pretty deep.

4. The DCS seemed intimidated to do any [redacted] care because they had not treated wounds.

5. The expectations were not to teach DSC [redacted] care, it was to teach them to clean feces or urine from around the [redacted] n order to prevent it from getting worse.

6. According to R [redacted] Nurse, the "Med Techs" (DCS who assist residents with the self-administration of their medications and cannot by regulation perform wound care to residents) were the ones that were able to reapply betadine on necrotic tissue (used to dry off the necrotic tissue to get it off the [redacted]. Meta-honey (wound and burn gel) was then placed on the healthy part of skin to ensure that it remained healthy. Next, they apply a skin barrier on the surrounding, healthy tissue, area to protect it. Eventually they added a [redacted]

7. R # [redacted] Nurse then increased her visits to three times per week on 07/31/23. Was wound care only provided on these days by hospice?

8. The facility RN and DCS #3 contacted R # [redacted] Nurse to come into the facility to train the DCS on how to clean skin areas around the wound.

9. R [redacted] Nurse stated that the "Med Techs" were the only DCS that did the wound the care. So was it the expectation o [redacted] hat only med techs were changing briefs?

10. She stated that the [redacted] process came about through mutual conversation/discussion on the best way to

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approach patient care. Training was about patient repositioning, oral care, and removing stool without contaminating the wound area. The "Med techs" seemed hesitant and intimidated, but they needed to learn how to properly clean the area around the wound. Why only Med Techs?

11. She stated that when she first came on board ([redacted] services on [redacted] was already unstageable. She taught the staff how to clean the area first, then apply wound cleanser, then fold a gauze in half, soak it in Betadine. Next they placed the gauze in the wound/towards the edges of the wound. The hope is that the necrotic sloughing would occur on the black part of the [redacted] itself so she could determine what was happening beneath. They placed enough Betadine soaked-gauze to cover it all. Then they place a skin barrier, very thick cream (zinc barrier cream), to keep the risk of breakdown on the healthy skin. The [redacted] itself must heal from the inside out and this requires good nutrition as well as [redacted] Since R[redacted] has been refusing food and not eating, this is a problem.

12. R[redacted] was transitioning t[redacted] at this time

[redacted]

Findings related to R #2

J. Record review of Complaint Intake #NM[redacted] received on 09/01/23, revealed that the complainant reported that R #2 told her Daughter/Power of Attorney (POA) that [redacted] was "Abused by a med tech with a bar of soap... and Patient stated 'I felt it was sexual.'...The person used the bar of soap so harshly o[redacted] bottom so hard that it still hurt and that was several days ago when it occurred." The incident happened a

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few days ago [redacted]/23), during a convesation between the Executive Director (ED) and R #2's Daughters/POAs, the ED confirmed that R #2 did report the incident and told them (Daughters/POAs) tha[redacted] had a meeting with R #2, and the alleged caregiver (DCS #1) to discuss the incident. According to the the Complaintant, R #2's Daughters/POAs were not contacted about the meeting and had not been made aware of the situation until a few days later when the resident finally called [redacted] daughter/POA and was distraught.

K. On 09/20/23 at 10:00 am, during an interview, R #2's Daughter/POA stated that the ED called her and her siblings to speak about the incident, the alleged sexual abuse was not disclosed, but they were informed the ED met with DCS #1 and R #2 regarding the incident. R #2's Daughter/POA and [redacted] siblings (also POAs) thought it was inappropriate that the meeting was conducted together (both DCS #1 and R #2) since it was conducted without the family involved or notified. R #2's Daughter/POA feels [redacted] needs an advocate when questioned.

L. On 09/20/23 at 11:33 am during an interview with former DCS #10 who worked for the facility until she resigned on 08/30/23 stated that on an unknown date and time, R #2 asked to talk to [redacted] [Former DCS #10] in the dining room. R #2 was shaking and pointed at DCS #1 and told her that the ED put both of them [DCS #1 and R #2] in the room to talk and DCS #1 kept speaking over [redacted] when [redacted] was talking and said"Nothing happened, right? Nothing happened, right?" R #2 was visibly shaking and on the verge of a panic attack as [redacted] told DCS #10.

M. On 09/21/23 at 11:30 am and 11:41 am, during

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A 033	Continued From page 25 an interview, the ED and RN stated: 1. On 08/21/23, DCS #1 wheeled R #2 in [redacted] from the dining room to the ED's office for R #2 to inform the ED about what happened while DCS #1 was cleaning [redacted] 2. DCS #1 was not asked to leave while the ED interviewed R #2. 3. R #2's family/POAs were not notified of the incident. 4. ED met with DCS #1 and determiend that DCS #1 had rubbed R #2 too hard and was retrained on incontinence. N. On 09/25/23 at 11:09 am during an interview, DCS #1 stated that on 08/21/23, R #2 was yelling and stating that DCS #1 violated [redacted] DCS #1 stated that she told R #2 "If you keep making up stories you are going to run out of caregivers to help you." At this time, DCS #1 wheeled R #2 to the ED's office. [redacted]	A 033		
A 034	7 NMAC 8.2.34 Custodial Drug Permits CUSTODIAL DRUG PERMITS: A facility with two (2) or more residents that is licensed pursuant to this rule and that assists with self-administration or safeguards medications for residents shall have a current custodial drug permit issued by the state board of pharmacy. A. Procurement, labeling and storage. The facility 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.	A 034	RN will ensure that oxygen tanks are labeled, secured, And stored properly in the oxygen room on the 1st floor of the community. RN will check oxygen tanks each Friday and sign the checklist located in the oxygen room to ensure continued compliance.	7/1/24

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A 034	Continued From page 26 (1) All medications, including non-prescription drugs, shall be stored in a locked compartment or in a locked room, as approved by the board of pharmacy and the key shall be in the care of the administrator or designee. (2) Internal medication shall be kept separate from external medications. Drugs to be taken by mouth shall be separated from all other delivery forms. (3) A separate, locked refrigerator shall be provided by the facility for medications. The refrigerator temperature shall be kept in compliance with the state board of pharmacy requirements for medications. (4) All medications, including non-prescription medications, shall be stored in separate compartments for each resident and all medications shall be labeled with the resident's name. (5) A resident may be permitted to keep his or her own medication in a locked compartment in his or her room for self-administration, if the physician's order deems it appropriate. (6) The facility shall not require the residents to purchase medications from any particular pharmacy. (7) Medical gases (oxygen) and equipment used for the administration of inhalation therapy and for resuscitative purposes shall comply with the national fire protection association (NFPA) 99. (8) A proof of use record shall be maintained separately for each schedule II through IV drug (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;	A 034		

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A 034	Continued From page 27	A 034		

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

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A 034	Continued From page 28 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: 7.8.2.34 A (7) This is a repeat deficiency from surveys dated 10/26/22 and 02/08/23. Refer to: NFPA (National Fire Prevention Association) 99. 2012 Edition. 11.3 Cylinder and Container Storage Requirements. 11.3.1* Storage for nonflammable gases equal to or greater than 85 m3 (3000 ft3) at STP shall comply with 5.1.3.3.2 and 5.1.3.3.3. 11.3.2* Storage for nonflammable gases greater than 8.5 m3 (300 ft3), but less than 85 m3 (3000 ft3), at STP shall comply with the requirements in 11.3.2.1 through 11.3.2.3. 11.3.2.1 Storage locations shall be outdoors in an enclosure or within an enclosed interior space of noncombustible or limited combustible construction, with doors (or gates outdoors) that can be secured against unauthorized entry. 11.3.2.2 Oxidizing gases, such as oxygen and nitrous oxide, shall not be stored with any flammable gas, liquid, or vapor. 11.3.2.3 Oxidizing gases such as oxygen and nitrous oxide shall be separated from combustibles or materials by one of the following: (1) Minimum distance of 6.1 m (20 ft) (2) Minimum distance of 1.5 m (5 ft) if the entire storage location is protected by an automatic	A 034		

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A 034	Continued From page 29 sprinkler system designed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems (3) Enclosed cabinet of noncombustible construction having a minimum fire protection rating of 1/2 hour 11.3.2.4 Gas cylinder and cryogenic liquid container storage shall comply with 5.1.3.5.12. 11.3.2.5 Cylinder and container storage locations shall comply with 5.1.3.3.1.7 with respect to temperature limitations. 11.3.2.6 Cylinder or container restraints shall comply with 11.6.2.3. 11.3.2.7 Smoking, open flames, electric heating elements, and other sources of ignition shall be prohibited within storage locations and within 6.1 m (20 ft) of outside storage locations. 11.3.2.8 Cylinder valve protection caps shall comply with 11.6.2.3. 11.3.2.9 Gas cylinder and liquefied gas container storage shall comply with 5.1.3.5.12. 11.3.3 Storage for nonflammable gases with a total volume equal to or less than 8.5 m3 (300 ft3) shall comply with the requirements in 11.3.3.1 and 11.3.3.2. 11.3.3.1 Individual cylinder storage associated with patient care areas, not to exceed 2100 m2 (22,500 ft2) of floor area, shall not be required to be stored in enclosures. 11.3.3.2 Precautions in handling cylinders specified in 11.3.3.1 shall be in accordance with 11.6.2. 11.3.3.3 When small-size (A, B, D, or E) cylinders are in use, they shall be attached to a cylinder stand or to medical equipment designed to receive and hold compressed gas cylinders. 11.3.3.4 Individual small-size (A, B, D, or E) cylinders available for immediate use in patient care areas shall not be considered to be in storage.	A 034		

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A 034	Continued From page 30 11.3.3.5 Cylinders shall not be chained to portable or movable apparatus such as beds and oxygen tents. 11.3.4 Signs. 11.3.4.1 A precautionary sign, readable from a distance of 1.5 m (5 ft), shall be displayed on each door or gate of the storage room or enclosure. 11.3.4.2 The sign shall include the following wording as a minimum: CAUTION: OXIDIZING GAS(ES) STORED WITHIN (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. Based on observation and interview, the facility failed to ensure that oxygen cylinder tanks were stored securely and protected from accidental damage or dislocation. This deficient practice could likely result in the 84 (R #s 1-84) residents listed on the resident census, provided by the Executive Director on 09/19/23, to be at risk of harm, injury, or death if oxygen cylinder tanks were to fall over damaging the valve, causing them to depressurize during a fire, the oxygen feeds the fire, causing it to spread faster and/or the cylinder tanks act like missiles and hit a resident/staff/rescuer during a fire. The findings are: A. On 09/19/23 at 3:45 pm, during observation of R[redacted] resident room: 1. Three (3) small cylinder tanks were unsecured on a bookshelf in the resident's room. 2. Three (3) large cylinder tanks were	A 034		

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A 034	Continued From page 31 unsecured on the floor near the resident's bed. B. On 09/21/23 at 2:55 pm, during observation of R[redacted] room, two (2) large unsecured cylinder tanks were in the bathroom near the shower. C. On 09/27/23 at 4:15 pm, during an interview with the Executive Director, he confirmed that: 1. Six (2) unsecured cylinder oxygen tanks were observed in R[redacted] room. 2. Two (2) unsecured cylinder oxygen tanks were observed in R #[redacted] room.	A 034		
A 038	7 NMAC 8.2.38 Housekeeping Services HOUSEKEEPING SERVICES. The facility shall maintain the interior and exterior of the facility in a safe, clean, orderly and attractive manner. The facility shall be free from offensive odors, safety hazards, insects and rodents and accumulations of dirt, rubbish and dust. A. All common living areas and all bathrooms shall be cleaned as often as necessary to maintain a clean and sanitary environment. B. Combustibles such as cleaning rags or flammable substances shall be stored in closed metal containers in approved areas that provide adequate ventilation. Combustibles shall be stored away from the food preparation areas and away from the resident rooms. C. Poisonous or flammable substances shall not be stored in residential areas, food preparation areas or food storage areas. If hazardous chemicals are stored on the property, material safety data sheets shall be maintained and stored in the same area as the chemicals, pursuant to state environment department requirements, 11.5.2.9 NMAC. [7.8.2.38 NMAC - Rp, 7.8.2.39 NMAC,	A 038	Facility has contracted pest control company to treat the property 7/11/24 weekly and as needed to maintain a pest-free environment. R#2's carpet was steam cleaned to remove stains. Staff has been advised to report any stains or housekeeping items of concern to Environmental Services Director or to the front desk so they can be put into system as a work order.	

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A 038	Continued From page 32 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.38 A This is a repeat deficiency for survey dated 10/26/22 and 02/08/23. Based on observation and interview, the facility failed to ensure that it was maintained in a safe, clean, orderly, and attractive manner, free from offensive odors, safety hazards, and insects. This deficient practice could likely result in the 84 (R #s 1-84) residents identified on the census provided by the ED on 09/19/23, to be at risk of harm, illness, or injury if the residents were to come into contact with bacteria from unsanitary conditions or insects. The findings are: A. On 09/20/23 at 7:50 am, during an observation of the private dining room, live ants were observed within the sink and on the countertop. B. On 09/27/23 at 9:14 am, during observation of R[redacted] room: 1. 2 large yellow stains were on the resident's carpet. 2. Insects (ants) were on the dresser close to the window. C. On 09/21/23 at 2:25 pm, during an interview, the Executive Director confirmed that the entire facility has ants, and he has been trying pest control preventions that have not worked.	A 038		

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A 049	Continued From page 33	A 049		7/1/24
A 049	7 NMAC 8.2.49 Doors DOORS: A. No door in any means of egress shall be locked against egress when the building is occupied. (1) Exit doors may be provided with a night latch, dead bolt, or security chain, provided these devices are operable from the inside, by any occupant, without the use of a key, tool, or any special knowledge and are mounted at a height not to exceed forty-eight (48) inches above the finished floor. (2) If locks are not readily operable by all occupants within the building, the locks must: 1) unlock upon activation of the fire detection or sprinkler system and 2) unlock upon loss of power in the facility. Prior to installing such locking devices, the facility shall have written approval from the building, fire and licensing authorities having jurisdiction. B. All exit doors shall have a minimum width of thirty-six (36) inches. (1) Facilities with a capacity of ten (10) or more residents shall have exit doors leading to the outside of the facility that open outward. (2) Facilities with a capacity of fifty (50) or more residents must provide panic hardware at the exit doors. (3) No door or path of travel to a means of egress shall be less than twenty-eight (28) inches wide. C. All resident sleeping room doors must be at least one and three-quarters (1 3/4) inch solid core construction. D. Bathroom doors may be twenty-four (24) inches wide. Facilities with four (4) or more residents shall have at least one bathroom for every eight (8) residents with a door clearance of thirty-six (36) inches for access by persons with	A 049	Local hardware company was contracted by facility to come and repair all pocket doors that were inoperable to ensure resident's privacy.	

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A 049	Continued From page 34 disabilities. E. Locks on doors to toilet rooms and bathrooms shall be capable of release from the outside. F. All doors shall readily open from the inside. G. Doors shall be provided for all resident sleeping rooms, all restrooms and all bathrooms. [7.8.2.49 NMAC - Rp, 7.8.2.50 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.49 G Based on observation and interview, the facility failed to ensure that for 1 (R #2) of 3 (R #s 2, 6, and 7) residents whose apartment and restroom doors were observed, the pocket doors in the bathrooms were operable and in good repair. The deficient practice could likely result in residents whose apartments have pocket doors in their bathrooms, to be denied privacy while using the bathroom. The findings are: A. On 09/19/23 at 3:45 pm, during observation of R #2's resident room, the bathroom pocket/sliding door was inoperable, preventing the resident from having privacy while using the bathroom. B. On 10/03/23 at 3:00 pm, during an interview, the Executive Director confirmed that R #2's resident bathroom pocket/sliding door was inoperable.	A 049	R# 1's screen has been replaced. All resident screens have been checked for damage and have been repaired or had a work order put into system to be replaced by an outside contractor.	7/1/24
A 059	7 NMAC 8.2.59 Windows WINDOWS: A. Each sleeping room shall be provided with an	A 059		

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A 059	Continued From page 35 exterior window. (1) The window shall be operable, screened and have a clear operable area of 5.7 square feet minimum; measured twenty (20) inches wide minimum and measured twenty-four (24) inches high minimum. (2) The top of the window sill shall not be more than forty-four (44) inches above the finished floor. B. Screens shall be provided on all operable windows. C. The proposed use of bars, grilles, grates or similar devices shall be reviewed and approved by the licensing authority prior to installation. D. Sleeping rooms, living rooms, activity room areas and dining room areas shall have a window area of at least one tenth (1/10) of the floor area with a minimum of ten (10) square feet. [7.8.2.59 NMAC - Rp, 7.8.2.52 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.59 B Based on observation and interview, the facility failed to ensure that all the facility's operable windows had screens that were in good repair. This deficient practice could likely result in the 84 (R #s 1-84) residents identified on the census provided by the Executive Director on 09/19/23 to be at risk of injury or illness if were bitten, insects got into the resident's food, and exposed to germs and bacteria from the bugs and insects the came through the damaged and missing window screens. The findings are: A. On 09/27/23 at 9:27 am, during observation of	A 059	Facility has contracted pesto control company to treat the property weekly and as needed to maintain a pest-free environment.	5/14/24

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A 059	Continued From page 36 R #1's window, the following was observed: 1. The window screen on the window facing [redacted]nd to the left of the resident bed had a bent frame. 2. That As you entered R#1's kitchen, ants (Insects) were crawling on the kitchen cabinet near the sink, where a plate of food was placed. B. On 09/28/23 at 1:59 pm, during an interview, the Executive Director confirmed: 1. The window screen in R #1's room was bent. 2. Insects (ants) were found crawling in R #1's room, and on the cabinet, and on the resident's plate containing food.	A 059		