Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	4017	A. BUILDING: _____ B. WING _____	C 09/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BLUE HORIZON BOUTIQUE ASSISTED LIVING & MEM	2707 SPITZ STREET BLDG A LAS CRUCES, NM 88005

(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 09/22/21 for the state requirements of 7 NMAC 8.2, Regulations for Assisted Living. Complaint #NM 44280 was substantiated with deficiencies cited. Complaint #NM 54566 was substantiated with deficiencies cited. Complaint #NM 48397 was unsubstantiated with no deficiencies cited.	A 000		
A 032	7 NMAC 8.2.32 Reporting of Incidents REPORTING OF INCIDENTS: A. The facility shall insure that all suspected cases or known incidents of resident abuse, neglect or exploitation are reported in accordance with 7.1.13 NMAC. (1) The facility shall also report any incident or unusual occurrence which has or could threaten the health, safety, or welfare of the residents and staff to the licensing authority complaint hotline within twenty-four (24) hours or by the next business day, if it is a weekend or a holiday. (2) The facility shall not delay a report to the complaint hotline while an internal investigation is conducted. B. The facility is responsible for conducting and documenting the investigation of all incidents within five (5) business days and shall submit a 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	A 032	#1 In regards to Violation A032 - facility will re-train all staff on Abuse, Neglect Exploitation Reporting as well as Incident Reporting both internal and to the state. Facility will include in training a method to report to administration anonymously in the event they ever fear retaliation for reporting anything internally. The method will be a drop box in which they can report any and all concerns they are no comfortable reporting in person. Training will emphasize the time requirement of reporting within 24 hours or if a weekend, on the next business day. THE ADMINISTRATOR WILL REPORT ALL STATE REPORTABLE INCIDENT REPORTS WITHIN 24 HOURS OF INCIDENT OR THE NEXT BUSINESS DAY. Address how you're going to monitor the corrective action and ensure ongoing compliance: Facility will monitor this corrective action by ensuring everyone is re-trained and by checking the drop box daily. ADMINISTRATOR WILL BE RESPONSIBLE FOR REPORTING ALL REPORTABLE STATE INCIDENT REPORTS WITHIN 24 HOURS OF INCIDENT OR THE NEXT BUSINESS DAY. Date Corrective Action will be Completed: Corrective action will be completed by 3/21/2022	

Division of Health Improvement
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Tracy Ayers

TITLE Administrator 3/14/2022 (X6) DATE 01/05/22

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A 032	Continued From page 1 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) 7.1.13 INCIDENT REPORTING, INTAKE, PROCESSING AND TRAINING REQUIREMENTS Refer to 7.1.13.7 W. & 8 B. (2) 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	A 032		

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A 032	Continued From page 2 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 2 (R #s 2 and 6) of 2 (R #s 2 and 6) residents whose internal incident reports were reviewed for compliance, that all allegations of physical abuse and incidents of unusual occurrence which has or could likely threaten the health, safety, or welfare of the resident were reported to the Licensing Authority within 24 hours or the next business day, if it is a weekend or a holiday. These deficient practice could likely result in the residents to be at risk of harm, injury, and/or death, if incidents occur and there is no oversight by the Licensing Authority. The findings are: Findings for R #2: A. Record review of R #2's Medication Administration Records (MARs) for June, July, and August of 2020 revealed that the resident received [redacted] as a scheduled medication and DCS #6's initials were on multiple entries. B. On 09/22/21 at 8:36 am, during an interview with DCS #3, she stated that DCS #6 had forced R #2 to take [redacted] on an unknown date during the summer of 2020, by [redacted]	A 032		

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A 032	Continued From page 3	A 032		

[redacted] despite R #2 refusing. DCS #3 stated she observed R #2 [redacted] DCS #3 stated she did not report the incident because DCS #6 was her supervisor and she was afraid of retaliation.

C. On 09/23/21 at 10:40 am, during an interview, DCS #6, she admitted to putting [redacted] R #2's [redacted] She stated she did not grab R #2's [redacted]

D. On 09/23/21 at 12:35 pm, during an interview with DCS #8, she confirmed that there was one time, during the summer of 2020, when she observed that R #2 was refusing to take [redacted] however, DCS #6 squirted the medication in [redacted]

E. On 09/22/21 at 1:21 pm, during an interview, the Administrator stated that she was not aware prior to the survey of the allegation against DCS #6 for having forced R #2 to take [redacted] during the summer of 2020, and therefore did not report the incident to the Licensing Authority.

Findings for R #6:

F. Record review of R #6's Internal Incident Report dated 02/02/21 revealed the following:

1. The report stated that on 02/02/21 at 8:30 am, R #6 was in [redacted] Direct Care Staff (DCS) heard a noise coming from the room, and went to check on the resident and [redacted] observed on the floor.

2. According to the report, R #6 told the DCS

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A 032	Continued From page 5 the incident because DCS #6 was her supervisor and she was afraid of retaliation. J. On 09/22/21 at 8:36 am, during review of an audio recording dated 08/05/20, DCS #6 is heard yelling at R #6 saying, "You don't get your way, you throw a fit like you're two-years-old. Stop, stop now! You're not slamming the door, get out there and eat! You don't get dessert, you don't get cookies, you don't get nothing!" K. On 09/23/21 at 10:40 am, during an interview, DCS #6, she denied having yelled at or verbally abused R #6 on 08/05/20. L. On 09/22/21 at 1:21 pm, during an interview, the Administrator stated that she was not aware of the allegation of DCS #6 being verbally abusive to R #6 on 08/05/20 and did not hear the audio recording prior to the survey, and therefore did not report the incident to the Licensing Authority.	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;	A 033	1. Address how all violations identified in the official statement of deficiencies will be corrected; In regards to tag A033, the facility will conduct re-training with all staff on resident rights. The facility will use this survey as an example where resident rights were violated and how that also relates to Abuse, Neglect and Exploitation and the 24 hour reporting requirement. 2. Address how the facility will monitor the corrective action and ensure ongoing compliance; The facility will monitor by ensuring the owner is involved in the initial re-training and the owner and administrator will monitor ongoing compliance by observation. We will continue to include this training in our new hire and annual training requirements. 3. Specify the date that the corrective action will be completed. The corrective action will be completed by 3/21/2022	

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A 032	Continued From page 4 that [redacted] 3. There was no documentation that the report was sent to the Licensing Authority. G. On 09/22/21 at 11:14 am, during an interview with R #6's [redacted] confirmed that: 1. [redacted] took R #6 out of the facility on [redacted] 21 to see [redacted] Primary Care Physician (PCP) because [redacted] According to R #6's [redacted] PCP did not order an X-ray until 02/22/21, when it revealed that R #6 had a [redacted] 2. R #6 told [redacted] that Direct Care Staff (DCS #s 1 and 7) [redacted] on 02/01/21. 3. R #6's [redacted] reported the allegation of physical abuse to the Administrator sometime after 02/02/21, however, [redacted] does not remember the exact date. H. On 09/22/21 at 1:21 pm, during an interview with the Administrator, she confirmed that she/facility did not report the incidents listed above to the Licensing Authority within 24 hours or the next business day if a holiday or weekend: 1. R #6's fall [redacted] 2. The allegation of physical abuse made by R #6's [redacted] against DCS #s 1 and 7. I. On 09/22/21 at 8:36 am, during an interview with DCS #3, stated she had an audio recording dated 08/05/20 of DCS #6 yelling at R #6 saying, "You don't get your way, you throw a fit like you're two-years-old. Stop, stop now! You're not slamming the door, get out there and eat! You don't get dessert, you don't get cookies, you don't get nothing!" DCS # 3 stated she did not report	A 032		

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A 033	Continued From page 6 (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. 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	A 033		

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A 033	Continued From page 7 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 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;	A 033		

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A 033	Continued From page 8 (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; 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 (1) (5) (10) (11) (a) Based on record review and interview, the facility failed to ensure for 2 (R #s 2 and 6) of 2 (R #s 2 and 6) residents that: 1. Their rights were protected and that the residents were treated with courtesy, respect, dignity, and compassion. 2. They received humane care. 3. They were free from the use of any and all physical or chemical restraints. 4. They were free from verbal abuse. This deficient practice could likely result in the residents to be at risk of harm, injury, and/or death if:	A 033		

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A 033	Continued From page 9 1. Resident rights are not protected and the Direct Care Staff (DCS) do not treat them with courtesy, respect, dignity, compassion, and in a humane manner. 2. Residents were placed at risk of harm, injury, or death if they were being physically or chemically restrained. The findings are: Findings for R #2 A. Record review of R #2's Medication Administration Records (MARs) for June, July, and August of 2020 revealed that the resident received [redacted] as a scheduled medication and DCS #6's initials were on multiple entries. B. On 09/22/21 at 8:36 am, during an interview with DCS #3, she stated that DCS #6 had forced R #2 to take her scheduled [redacted] on an unknown date during the summer of 2020, by [redacted] despite R #2 refusing. DCS #3 stated she observed R #2 [redacted] after the incident. DCS #3 stated she did not report the incident because DCS #6 was her supervisor and she was afraid of retaliation. C. On 09/22/21 at 1:21 pm, during an interview, the Administrator stated that she was not aware prior to the survey of the allegation against DCS #6 for having forced R #2 to take [redacted] during the summer of 2020. D. On 09/23/21 at 10:40 am, during an interview, DCS #6, [redacted] admitted to putting [redacted] in R	A 033		

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A 033	Continued From page 10 #2's [redacted] She stated she did not grab R #2's [redacted] E. On 09/23/21 at 12:35 pm, during an interview with DCS #8, she confirmed that there was one time, during the summer of 2020, when she observed that R #2 was refusing to take [redacted] however, DCS #6 [redacted] Findings for R #6 F. On 09/22/21 at 8:36 am, during an interview with DCS #3, stated she had an audio recording dated 08/05/20 of DCS #6 yelling at R #6 saying, "You don't get your way, you throw a fit like you're two-years-old. Stop, stop now! You're not slamming the door, get out there and eat! You don't get dessert, you don't get cookies, you don't get nothing!" DCS # 3 stated she did not report the incident because DCS #6 was her supervisor and she was afraid of retaliation. G. On 09/22/21 at 8:36 am, during review of an audio recording dated 08/05/20, DCS #6 is heard yelling at R #6 saying, "You don't get your way, you throw a fit like you're two-years-old. Stop, stop now! You're not slamming the door, get out there and eat! You don't get dessert, you don't get cookies, you don't get nothing!" H. On 09/22/21 at 1:21 pm, during an interview, the Administrator stated that she was not aware of the allegation of DCS #6 being verbally abusive to R #6 on 08/05/20 and did not hear the audio recording prior to the survey. I. On 09/23/21 at 10:40 am, during an interview,	A 033		

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A 033	Continued From page 11 DCS #6, she denied having yelled at or verbally abused R #6 on 08/05/20. J. On 10/18/21 at 12:24 pm, during a follow-up interview with the Administrator, she confirmed the voice in the audio recording was that of DCS #6 and agreed that what she heard on the audio was verbal abuse and confirmed that she did not know about the incident prior to the survey and therefore did not report it to the Licensing Authority.	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. (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	A 034	1. Address how all violations identified in the official statement of deficiencies will be corrected; In regards to Tag A034 - facility will order outside storage for all oxygen tanks. In regards to the Oxygen in Use signs, facility has ordered these signs and will place them at the doors of all rooms with oxygen, as well as the main entrance. 2. How will you monitor the correction to ensure future compliance The administrator will do a weekly walk through to ensure proper storage of all oxygen tanks and that all necessary Oxygen in Use signs are posted appropriately. 3. Date correction will be made Correction will be made by 2/15/2022	2/15

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BLUE HORIZON BOUTIQUE ASSISTED LIVING & MEN	2707 SPITZ STREET BLDG A LAS CRUCES, NM 88005

(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 12 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; (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	A 034		

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A 034	Continued From page 13 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 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) Reference NFPA 99 (Healthcare Facilities Code)	A 034		

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A 034	Continued From page 14 2012 Edition NFPA 99. 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 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	A 034		

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A 034	Continued From page 15 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	A 034		

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A 034	Continued From page 16 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. 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 NO SMOKING 2012 Edition Based on observation and interview, the facility failed to ensure that: 1. Oxygen cylinder tanks were stored securely and protected from accidental damage or dislocation. 2. Oxygen in-use signs were posted outside resident rooms. These deficient practices could likely result in the 9 (R #s 1 through 9) residents identified on the resident census list provided by the Administrator on 09/20/21, to be at risk of harm, injury, or death if: 1. The 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	A 034		

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A 034	Continued From page 17 tanks act like missiles and hit a resident/staff/rescuer during a fire. 2. There were no "oxygen in use" signs posted on the outside of the room doors, if a fire were to occur and first responders are not aware there is oxygen in use that could accelerate the fire. The findings are: A. On 09/20/21 at 3:20 pm, during an observation of the facility, the following was observed. 1. In resident room #1, three (3) unsecured oxygen tanks. 2. Just outside of resident room #2, in the hallway, was one (1) unsecured oxygen tank. 3. In resident room #3, there were two (2) unsecured oxygen tanks in the bedroom and two (2) unsecured oxygen tanks in the bathroom. B. On 09/20/21 at 3:20 pm, during an observation of rooms #s 1, 2, and 3 there were no oxygen in use signs observed to be posted outside the resident's rooms. C. On 09/22/21 at 1:37 pm, during an interview with the Administrator, she confirmed that there were unsecured oxygen tanks: 1. Inside resident rooms #s 1 & 3. 2. In the hallway outside of resident room #2. 3. In the bathroom of resident room #3. 4. And there were no "Oxygen in Use" signs posted outside the resident's room doors.	A 034		
A 035	7 NMAC 8.2.35 Medication MEDICATIONS: Administration of medications or staff assistance with self-administration of	A 035		

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A 035	Continued From page 18 medications shall be in accordance with state and federal laws. No medications, including over-the-counter medications, PRN (when needed) medications, or treatment shall be started, changed or discontinued by the facility without an order from the physician, physician assistant or nurse practitioner and with entry into the resident's record. A. State board of nursing licensed or certified health care professionals are responsible for the administration of medications. Administration may only be performed by these individuals. B. Facility staff may assist a resident with the self-administration of medications if written consent by the resident is given to the administrator of the facility or the administrator ' s designee. If the resident is incapable of giving consent, the surrogate decision maker named in accordance with New Mexico law may give written consent for assistance with self-administration of medications. All staff that assist with self-administration of medications shall have successfully completed a state approved assistance with self-administration of medication training program or be licensed or certified by the state board of nursing. C. PRN (pro re nada) medication. (1) Physician or physician extender ' s orders for PRN medications shall clearly indicate the circumstances in which they are to be used, the number of doses that may be given in a 24-hour period and indicate under what circumstances the primary care practitioner (PCP) is to be notified. (2) The utilization of PRN medications shall be reviewed routinely. Frequent or escalating use of PRN medications shall be reported to the PCP. D. Only a licensed nurse (RN or LPN) shall administer any medications or conduct any invasive procedures provided by the following	A 035	1. Address how all violations identified in the official statement of deficiencies will be corrected; In regards to Tag A035, the facility will work with the data entry Pharmacy to ensure that all the brand/ generic names are corrected on the MAR 2. Address how the facility will monitor the corrective action and ensure ongoing compliance: The administator of the facility will do a monthly MAR audit to ensure that all brand/generic names are placed appropriately on the MAR 3. Specify the date that the corrective action will be completed The date the corrective action will be completed is 2/15/2022.	

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A 035	Continued From page 19 routes: intravenous (IV), subcutaneous (SQ), intramuscular (IM), vaginal or rectal. Only a licensed nurse shall administer non-premixed nebulizer treatments. E. The facility shall have medication reference material that contains information relating to drug interactions and side effects on the premises. Staff that assist in the self-administration of medications shall know interactions or possible side effects that might occur. F. Medications prescribed for one resident shall not be used for another resident. G. Medication assistance record (MAR). For residents who are not independent and require assistance with self administration, the facility shall have a MAR that documents the details of the residents' medication, including PRN and over-the-counter medication that is assisted with self-administration by qualified staff or administered to the resident by licensed or certified staff. The information in the MAR shall include: (1) the resident's name; (2) any known allergies to medication that the resident has; (3) the name of the resident's PCP or the prescriber of the medication; (4) the diagnosis or reason for the medication; (5) the name of the medication, including the drug product brand name and the generic name; (6) notation if the medication is a schedule II-IV drug; (7) the dosage of the medication; (8) the strength of the medication; (9) the frequency or how often the medication is to be taken or given; (10) the route of delivery for the medication (mouth, eye, ear, other); (11) the method of delivery for the medication	A 035		

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A 035	Continued From page 20 (pills, drops, IM injection, other); (12) the date that the medication was started or discontinued; (13) any change in the medication order; (14) pre-medication information (i.e., pulse, respiration, blood pressure, blood sugar) as required by the medication order; (15) the date and time that the medication is self-administered, administered with assistance or is administered; (16) the initials and signature of the person assisting with or administering the medication; (17) the desired results obtained from or problems encountered with the medication (pain relieved, allergic reaction, etc.); (18) any refused dose of medication; (19) any missed dose of medication; and (20) any medication error. H. No medication shall be stopped or started without specific orders from the primary care physician. I. If a resident refuses to take a prescribed medication, it shall be documented and the facility shall report it to the prescriber. J. A suspected adverse reaction to a medication shall be documented on the MAR and reported immediately to the PCP and the resident's surrogate decision maker. If applicable, emergency medical treatment shall be arranged. Documentation of the event shall be kept in the resident's record. K. Prescription medication, other than blister packs and unit dose containers, shall be kept in the original container with a pharmacy label that includes the following: (1) the resident's name; (2) the name of the medication; (3) the date that the prescription was issued; (4) the prescribed dosage and the instructions for	A 035		

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A 035	Continued From page 21 administration of the medication; and (5) the name and title of the prescriber. L. Any medication that is removed from the pharmacy container or blister pack shall be given immediately and documented by the staff that assisted with the medication delivery. M. The facility shall report all medication errors to the physician, documentation of medication errors and the prescriber's response shall be kept in the resident's record. N. The facility shall develop and follow a written policy for unused, outdated, or recalled medications kept in the facility in accordance with 16.19.11.10 NMAC (AS AMENDED). [7.8.2.35 NMAC - Rp, 7.8.2.35 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.35 G (5) Based on record review and interview the facility failed to ensure for 3 (R #s , 2 and 3) of 4 (R #s 1 through 4) residents whose Medication Administration Records (MARs) were reviewed for compliance that they included both the brand and generic names for all medications. This deficient practice could likely result in the residents being at risk of harm, if the Direct Care Staff (DCS) who assist residents with the self-administration of medications do not know or recognize the generic/brand names of the medications and errors occur due to this vital information missing on the MARs. The findings are: A. Record review of R #1's 09/01/21 through	A 035		

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A 036	Continued From page 23 recommended daily dietary allowance " of the American dietetic association, the food and nutrition board of the national research council, or the national academy of sciences. Meals shall meet the nutritional needs of the residents in accordance with the " 2005 USDA dietary guidelines for Americans. " Vending machines shall not be considered a source of snacks. A. Dietary services policies and procedures. The facility will develop and implement written policies and procedures that are maintained on the premises and that govern the following requirements. (1) Meal service. The facility shall: (a) serve at least three (3) meals or their equivalent each day at regular times with no more than sixteen (16) hours between the evening meal and morning meal with snacks freely available; (b) provide snacks of nourishing quality and post on the daily menu; (c) develop menus enjoyed by the residents and served at normal intervals appropriate to the residents ' preferences; (d) post the weekly menu, including snacks where residents and families are able to view it; posted menus shall be followed and any substitution shall be of equivalent nutritional value and recorded on the posted menu; identical menus shall not be used within a one (1) week cycle; (e) have special menus or meal items following guidelines from the resident ' s physician for residents who have medically prescribed special diets; (f) serve all residents in a dining room except for residents with a temporary illness, or with documented specific personal preference to have meals in their room;	A 036	1. Address how all violations identified in the official statement of deficiencies will be corrected; With regards to Tag A036, the facility will remove all expired items immediately; the facility will check the items to ensure proper labeling; the facility will monitor the temperature. 2. Address how the facility will monitor the corrective action and ensure ongoing compliance; The Administrator will re-train the staff on proper food storage. The administrator will create a check-off sheet wherein each scheduled shift, the assistant manage will check for and dispose of any expired items; ensure all items are properly labeled and ensure the temperatures are within range. This will be done for 90 days to ensure staff all have an understanding of the requirements. We will continue to log temperatures daily as we already do, in our computer system. 3. Specify the date that the corrective action will be. The corrective action will be completed on 3/21/2022	

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A 035	Continued From page 22 09/21/21 MAR revealed that it did not include both the brand/generic names for [redacted] B. Record review of R #2's 09/01/21 through 09/21/21 MAR revealed that it did not include both the brand/generic names for: [redacted] C. Record review of R #3's 09/01/21 through 09/21/21 MAR revealed that it did not include both the brand/generic names for: [redacted] D. On 09/21/21 at 2:03 pm, during an interview with the Administrator, she confirmed that the 09/01/21 through 09/21/21 MARs for R #s 1 through 3 did not include both the Brand/Generic names for the above listed medications.	A 035		
A 036	7 NMAC 8.2.36 Nutrition NUTRITION: The facility shall provide planned and nutritionally balanced meals from the basic food groups in accordance with the "	A 036		

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A 036	Continued From page 24 (g) allow sufficient time for meals to enable residents to eat at a leisurely pace and to socialize; and (h) contact the resident ' s PCP within forty-eight (48) hours if a resident consistently refuses to eat. (2) Staff in-service training. The facility shall provide an in-service training program for staff that are involved in food preparation at orientation and at least annually and that includes: (a) instruction in proper food storage; (b) preparation and serving food; (c) safety in food handling; (d) appropriate personal hygiene; and (e) infectious and communicable disease control. B. Dietary records. The facility shall maintain the following documentation onsite: (1) a systematic record of all menus and revisions, including snacks, for a minimum of thirty (30) calendar days; (2) a systematic record of therapeutic diets as prescribed by a PCP; (3) a copy of the most recent licensing inspection and for facilities with 10 or more residents, a copy of the New Mexico environment department inspection with notations made by the facility of action taken to comply with recommendations or citations; and (4) a daily log of the recorded temperatures for all facility refrigerators, freezers and steam tables maintained and available for inspection for thirty (30) calendar days. C. Clean and sanitary conditions. All practices shall be in accordance with the standards of the state environment department, pursuant to 7.6.2 NMAC. (1) Kitchen sanitation. (a) Equipment and work areas shall be clean and in good repair. Surfaces with which food or	A 036		

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	4017	A. BUILDING: _____ B. WING _____	C 09/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BLUE HORIZON BOUTIQUE ASSISTED LIVING & MEM	2707 SPITZ STREET BLDG A LAS CRUCES, NM 88005

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A 036	Continued From page 25 beverages come into contact shall be of smooth, impervious material free of open seams, not readily corrodible and easily accessible for cleaning. (b) Utensils shall be stored in a clean, dry place protected from contamination. (c) The walls, ceiling and floors of all rooms that food or drink is stored, prepared or served shall be kept clean and in good repair. (2) Washing and sanitizing kitchenware. (a) All reusable tableware and kitchenware shall be cleaned in accordance with procedures that include separate steps for prewashing, washing, rinsing and sanitizing. (b) Proper dishwashing procedures and techniques shall be utilized and understood by the dishwashing staff. (c) Periodic monitoring of the operation of the detergent dispenser, washing, rinsing and sanitizing temperatures shall be performed and documented. (d) When a dishwashing machine is utilized, the cleanliness of the machine, its jets and its thermostatic controls shall be monitored and documented by the facility. A monthly log of the recorded temperature of the dishwasher shall be maintained in the facility and available for inspection. (3) Sinks for hand washing shall include hot and cold running water, hand-washing soap and disposable towels. (4) All garbage and kitchen refuse that is not disposed of through a garbage disposal unit shall be kept in watertight containers with close-fitting covers and disposed of daily in a safe and sanitary manner. (5) Cooks and food handlers shall wear clean outer garments and hair nets or caps and shall keep their hands clean at all times when engaged	A 036		

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A 036	Continued From page 26 in handling food, drink, utensils or equipment in accordance with the local health authority. Disposable gloves shall be used in accordance with the local health authority. D. Food management. The facility shall store, prepare, distribute and serve food under sanitary conditions and in accordance with the regulations governing food establishments of local health authority having jurisdiction, 7.6.2 NMAC. (1) The facility shall ensure that a minimum of a three (3) calendar day supply of perishables and a five (5) calendar day supply of non-perishables or canned foods is available for the residents. (2) The facility refrigerator and freezer shall have an accurate thermometer which reads within or not more than plus or minus three (3) degrees fahrenheit of the required temperature, located in the warmest section of the refrigerator and freezer and shall be accessible and easily read. (a) The temperature of the refrigerator shall be thirty-five (35) - forty-one (41) degrees fahrenheit. (b) Freezer temperatures shall be maintained at zero (0) degrees fahrenheit or below. (3) Refrigerators and freezers shall be kept clean and sanitary at all times. Food stored in refrigerators and freezers shall be covered, dated and labeled. Unused leftover food shall be discarded after three (3) calendar days. (4) Steam tables, hot food tables, slow cookers, crock pots and other hot food holding devices shall not be used in heating or reheating food. Hot food temperatures shall be checked periodically to insure that a minimum of one hundred forty (140) degrees fahrenheit is maintained. (5) Medication, biological specimens, poisons, detergents and cleaning supplies shall not be kept in the same storage areas used for storage of foods. Medications shall not be stored in the	A 036		

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A 036	Continued From page 27 refrigerator with food; an alternate refrigerator for medication shall be used pursuant to Subsection B of 7.6.2.8 NMAC. (6) Canned or preserved foods shall be procured from sources that process the food under regulated quality and sanitation controls. This does not preclude the use of local fresh produce. The facility shall not use home-canned foods. (7) Dry or staple food items shall be stored at least six (6) inches off the floor in a ventilated room that is not subject to sewage, waste water back-flow or contamination by condensation, leakage, rodents or vermin. (8) The facility shall ensure the following: (a) all perishable food is refrigerated and the temperature is maintained no higher than forty-one (41) degrees fahrenheit; (b) the temperature for all hot foods is maintained at one hundred forty (140) degrees fahrenheit; and (c) all displayed or transported food is protected from environmental contamination and maintained at proper temperatures in clean containers, cabinets or serving carts. E. Milk. (1) Raw milk shall not be used. (2) Condensed, evaporated, or dried milk products that are nationally recognized may be employed as " additives " in cooked food preparation but shall not be substituted or served to residents in place of milk. F. Collateral requirements. Compliance with this rule does not relieve a facility from the responsibility of meeting more stringent municipal regulations, ordinances or other requirements of state or federal laws governing food service establishments. Local health authority having jurisdiction means municipal, county, state or federal agency(s) that have laws and regulations	A 036		

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A 036	Continued From page 28 governing food establishments, liquid waste disposal, treatment facilities and private wells. [7.8.2.36 NMAC - Rp, 7.8.2.37 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.36 D (3) (a) Based on observation and interview, the facility failed to ensure that: 1. The temperature of the refrigerator was thirty-five (35) through forty-one (41) degrees Fahrenheit (F). 2. Refrigerators and freezers were kept clean and sanitary at all times and the food stored in the refrigerators and freezers were dated, labeled, and unused leftover food was discarded after three (3) calendar days. These deficient practices could likely result in the 9 (R #s 1 through 9) residents listed on the resident census provided by the Administrator on 09/20/21, to be at risk of contracting foodborne illnesses if the food: 1. Becomes spoiled and unsafe to eat because the refrigerator's temperature was not maintained between 35 and 41 egress F 2. Was not stored properly (dated, labeled), were served past their expiration dates, and/or leftovers were kept longer than (3) three days after being served the first time. The findings are: A. On 09/21/21 at 9:03 am, during an observation of the kitchen, it was revealed that the far right refrigerator temperature was 42.7	A 036		

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A 036	Continued From page 29 degrees F. B. On 09/21/21 at 9:08 am, during an observation of the freezer on the right side, the following foods were observed: 1. (2) two undated 14-ounce loaves of French bread 2. (1) one undated 32-ounce package of opened hash brown potatoes 3. (1) one undated 12-ounce package of yellow squash 4. (1) one undated 16-ounce package of corn 5. (1) one undated 64-ounce package of sliced strawberries 6. (1) one undated 6-count package of waffles 7. (1) one undated 6-count opened package of waffles C. On 09/21/21 at 9:08 am, during an observation of the refrigerator, the following was observed: 1. (2) two 12-ounce cans of orange juice that were expired. 2. (1) one 1.5-pound package of turkey breast that was past used/opened date. 3. (2) two 10-count flour tortilla packages that were expired 4. (1) one bowl of leftover cut watermelon past 3 days of first use 5. (1) one undated container of eggs (some used) 6. (1) one undated 40-ounce bag of celery sticks 7. (1) one undated head of lettuce 9. (1) one 8-ounce package of nutrition drink that was expired 10. (1) one 32-ounce carton of opened whipping cream that was expired	A 036		

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A 036	Continued From page 30 D. On 09/21/21 at 9:08 am, during an observation of the freezer on the left side, the following was located: 1. (1) one undated 160-ounce container of opened vanilla ice cream 2. (1) one undated bag of opened blueberries 3. (1) one undated 4-pound package of sausage 4. (1) one undated 1-pound package of bacon 5. (1) one undated 16-ounce package of Italian sausage 6. (1) one undated 16-ounce package of ground turkey 7. (1) one undated 7.46-pound package of chicken breasts E. On 09/21/21 at 9:50 am, during an interview with the Administrator, she confirmed: 1. That the temperature in the far right refrigerator, was not maintained thirty-five (35) through forty-one (41) degrees Fahrenheit (F). 2. The findings listed above for the foods not being dated and/or expired. 3. That leftover food was not being thrown put after 3 days.	A 036	1. Address how all violations identified in the official statement of deficiencies will be corrected; In regards to Tag A037, the staff will all be re-trained by the administrator on the laundry services regulation and the door will be kept locked at all times.	
A 037	7 NMAC 8.2.37 Laundry Services LAUNDRY SERVICES: A. General requirements. The facility shall provide laundry services for the residents, either on the premises or through a commercial laundry and linen service. (1) On-site laundry facilities shall be located in areas separate from the resident units and shall be provided with necessary washing and drying equipment.	A 037	2. Address how the facility will monitor the corrective action and ensure ongoing compliance; the aministrator will monitor the corrective action by visually observing the door is locked throughout the day. 3. Specify the date that the corrective action will be completed. Corrective action will be completed on 3/21/2022	✓

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A 037	Continued From page 31 (2) Soiled laundry shall be kept separate from clean laundry, unless the laundry facility is provided for resident use only. (3) Staff shall handle, store, process and transport linens with care to prevent the spread of infectious and communicable disease. (4) Soiled laundry shall not be stored in the kitchen or dining areas. The building design and layout shall ensure the separation of laundry room from kitchen and dining areas. An exterior route to the laundry room is not an acceptable alternative, unless it is completely enclosed. (5) In new construction or newly licensed facilities with more than fifteen (15) residents, washers shall be in separate rooms from dryers. The rooms with washers shall have negative air pressure from the other facility rooms. (6) All linens shall be changed as needed and at least weekly or when a new resident is to occupy the bed. (7) The mattress pad, blankets and bedspread shall be laundered as needed and at least once per month or when a new resident is to occupy the bed. (8) Bath linens consisting of hand towel, bath towel and washcloth shall be changed as needed and at least weekly. (9) There shall be a clean, dry, well ventilated storage area provided for clean linen. (10) Facility laundry supplies and cleaning supplies shall not be kept in the same storage areas used for the storage of foods and clean storage and shall be kept in a secured room or cabinet. B. Residents may do their own laundry, if it is their preference and they are capable of doing so, or if it is part of their skill-building for independent living and is documented as part of their ISP. [7.8.2.37 NMAC - Rp, 7.8.2.39 NMAC,	A 037		

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A 037	Continued From page 32 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.37 A (10) Based on observation and interview, the facility failed to ensure that the cleaning and laundry supplies were kept in a secured room, closet, or cabinet. This deficient practice could likely result in the 9 (R #s 1 through 9) residents identified on the census list provided by the Administrator on 09/20/21, to be at risk of harm, injury, or death if they were to ingest or spill laundry or cleaning supplies on their face or body. The findings are: A. On 09/21/21 at 10:41 am, during an observation of the unlocked laundry room, the following was observed: 1. In the cabinet above the washer and dryer (1) one 130-count container of laundry detergent pods 2. In the cabinet under the sink on the left-hand side: a. (1) one 1-gallon of multi surface cleaner b. (1) one 1-gallon of industrial cleaner and degreaser 3. In the cabinet under the sink on the right-hand side: a. (2) two 1-gallon containers of bleach b. (1) one 1-gallon container of industrial cleaner and degreaser c. (1) one 26-ounce spray bottle of glass cleaner d. (2) two 9.7-ounce cans of furniture polish spray	A 037		

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A 037	Continued From page 33 e. (1) one 19-ounce can of disinfectant spray f. (1) one 24-ounce spray bottle of industrial cleaner and degreaser B. On 09/21/21 at 3:37 pm, during an interview with the Administrator, she confirmed that the above listed cleaning/laundry supplies were being stored in unlocked cabinets, in the unlocked laundry room, and accessible to the residents some with dementia (memory loss).	A 037		
A 045	7 NMAC 8.2.45 Water WATER: Pursuant to the current New Mexico drinking water requirements, 7.6.2.9 NMAC. A. The water supply system shall be constructed, protected, operated and maintained in conformance with applicable local, state and federal laws, ordinances and regulations. B. Where a facility is supplied by its own water system, the system shall meet the sampling and construction requirement of a non-community water system as defined by the current New Mexico drinking water requirements. C. All water that is not piped into the facility directly from a public water supply system shall be from an approved source, disinfected, transported, handled, stored and dispensed in a sanitary manner. Such water shall be prevented from entering potable water systems by appropriate cross connection and backflow prevention devices. D. Hot and cold running water, under pressure shall be provided in all areas where food is prepared and where equipment and utensils are washed, sinks, lavatories, washrooms and laundries. E. The hot water temperature that is accessible to	A 045	1. Address how all violations identified in the official statement of deficiencies will be corrected; in regards to Tag 045, the hot water heaters will all be turned down to ensure compliance with the temperature regulation. 2. Address how the facility will monitor the corrective action and ensure ongoing compliance; the administrator will retrain all staff on the regulation and on our existing requirement to check and log water temperatures and will check the logs on a weekly basis to ensure compliance. 3. Specify the date that the corrective action will be completed. The corrective action will be completed by 3/21/2022	✓

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A 045	Continued From page 34 residents shall be maintained at a minimum of ninety-five (95) degrees fahrenheit and a maximum of one hundred ten (110) degrees fahrenheit. Hot water in excess of one hundred ten (110) degrees fahrenheit is permitted in kitchen and laundry areas, provided that residents are supervised in order to prevent injury. [7.8.2.45 NMAC - Rp, 7.8.2.46 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.45 (E) Based on observation and interview, the facility failed to ensure that the hot water temperatures were maintained at a maximum of 110 degrees Fahrenheit (F). This deficient could likely cause harm to the 9 (R #s 1 through 9) residents listed on the census list provided by the Administrator on 09/20/21, to be at risk of being burned by water that is too hot. The findings are: A. On 9/21/21 at 11:32 am, during observation of resident room #4, the bathroom sink water was found to be at 130 degrees F. B. On 9/21/21 at 11:36 am, during observation of resident room #1, the bathroom sink water was found to be at 127 degrees F. C. On 9/21/21 at 3:37 pm, during an interview with the Administrator, she confirmed the water temperature in rooms 1 and 4 were above 110 degrees F.	A 045		

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A 059	Continued From page 35	A 059		
A 059	7 NMAC 8.2.59 Windows WINDOWS: A. Each sleeping room shall be provided with an 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 A (1) C Based on observation and interview, the facility failed to ensure that: 1. Windows in resident rooms were operable and able to be opened. 2. The use of bars, grilles, grates, or similar devices were reviewed and approved by the Licensing Authority prior to installation. This deficient practice could likely result in the 9 (R #s 1 through 9) residents identified on the	A 059	1. Address how all violations identified in the official statement of deficiencies will be corrected; In regards to Tag 059, all locks will be removed from the windows and window alarms will replace the locks. 2. Address how the facility will monitor the corrective action and ensure ongoing compliance; Facility will monitor by having the administrator check for locks during her daily walk through. 3. Specify the date that the corrective action will be completed. Corrective action will be complete on 3/21/2022	✓

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A 059	Continued From page 36 resident census list provided by the Administrator on 09/20/21, to be at risk of harm, injury, or death, if they are unable to evacuate in the event of a fire, loss of power, or emergency that requires evacuation. The findings are: A. On 09/21/21 at 9:00 am, during observation of the facility windows, it was observed that resident room #s 1 through 11 had a bolted, metal clamp installed into the window frame, preventing them from opening. B. On 09/21/21 at 1:37 pm, during an interview with the Administrator, she confirmed the following: 1. The windows had the bolted, metal clamps installed in the window frame to prevent them from being opened to save on utility expenses. 2. The facility did not have a variance or prior approval from the Licensing Authority to install the clamps on the windows.	A 059		