

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 2282	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 04/22/2022
NAME OF PROVIDER OR SUPPLIER PUEBLO OF ISLETA ASSISTED LIVING & MEM CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 1001 & 1003 TRIBAL RD #140 ISLETA, NM 87022		
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A 000	Initial Comments The following deficiencies were cited during a Full-/Complaint survey conducted on 04/22/22 for the state requirements of 7 NMAC 8.2, Regulations for Assisted Living. Complaint NM #55381 was substantiated with deficiencies cited. Complaint NM #50547 was substantiated with deficiencies cited.	A 000		
A 016	7 NMAC 8.2.16 Staff Qualifications STAFF QUALIFICATIONS: A facility shall employ staff with the following qualifications. A. Administrator, director, operator: an assisted living facility shall be supervised by a full-time administrator. Multiple facilities that are located within a forty (40) mile radius may have one full-time administrator. The administrator shall: (1) be at least twenty-one (21) years of age; (2) have a high school diploma or its equivalent; (3) comply with the requirements of the New Mexico Caregivers Criminal History Screening Act, 7.1.9 NMAC; (4) complete a state approved certification program for assisted living administrators; (5) be able to communicate with the residents in the language spoken by the majority of the residents; (6) not work while under the influence of alcohol or illegal drugs; (7) have evidence of education and experience to prove the ability to administer, direct and operate an assisted living facility; the evidence of education and experience shall be directly related to the services that are provided at the facility; (8) provide three (3) notarized letters of reference from persons unrelated to the applicant; and (9) comply with the pre-employment requirements	A 016	A 016 Upon receipt of Request for Variance denial from DOH, the facility obtained approval from Pueblo of Isleta Department of Treasury for funding and account setup with state's required 3 rd party fingerprinting administrator and CCHSP. All current employees were cleared against the Employee Abuse Registry, and were fingerprinted and background checked per regulation, expecting all employees to clear by October 19, 2022. Going forward, the Administrator and HR Director will ensure all new Employees will be cleared through CCHSP prior to hire.	

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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A 016	Continued From page 1 pursuant to the Employee Abuse Registry, 7.1.12 NMAC. B. Direct care staff: (1) shall be at least eighteen (18) years of age; (2) shall have adequate education, relevant training, or experience to provide for the needs of the residents; (3) shall comply with the pre-employment requirements pursuant to the Employee Abuse Registry, 7.1.12 NMAC; and (4) shall comply with the current requirements of reporting and investigating incidents pursuant to Incident Reporting, Intake Processing and Training Requirements, 7.1.13 NMAC; (5) if a facility provides transportation for residents, the employees of the facility who drive vehicles and transport residents shall have copies of the following documents on file at the facility: (a) a valid New Mexico driver ' s license with the appropriate classification for the vehicle that is used to transport residents; (b) documentation of training in transportation safety for the elderly and disabled, including safe vehicle operation; (c) proof of insurance; and (d) documentation of a clean driving record; (6) any person who provides direct care who is not employed by an agency that is covered by the requirements of the Caregivers Criminal History Screening Requirements, 7.1.9 NMAC, shall provide current (within the last 6 months) proof of the caregivers criminal history screening to the facility; the facility shall maintain and have proof of such screening readily available; and (7) employers shall comply with the requirements of the Caregivers Criminal History Screening Requirements, 7.1.9 NMAC. [7.8.2.16 NMAC - Rp, 7.8.2.16 NMAC,	A 016		

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NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

PUEBLO OF ISLETA ASSISTED LIVING & MEM CARE

1001 & 1003 TRIBAL RD #140
ISLETA, NM 87022

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A 016	Continued From page 2 01/15/2010]	A 016		
	This REQUIREMENT is not met as evidenced by: 7.1.12.8 REGISTRY ESTABLISHED; PROVIDER INQUIRY REQUIRED: Upon the effective date of this rule, the department has established and maintains an accurate and complete electronic registry that contains the name, date of birth, address, social security number, and other appropriate identifying information of all persons who, while employed by a provider, have been determined by the department, as a result of an investigation of a complaint, to have engaged in a substantiated registry-referred incident of abuse, neglect or exploitation of a person receiving care or services from a provider. Additions and updates to the registry shall be posted no later than two (2) business days following receipt. Only department staff designated by the custodian may access, maintain and update the data in the registry. A. Provider requirement to inquire of registry. A provider, prior to employing or contracting with an employee, shall inquire of the registry whether the individual under consideration for employment or contracting is listed on the registry. B. Prohibited employment. A provider may not employ or contract with an individual to be an employee if the individual is listed on the registry as having a substantiated registry-referred incident of abuse, neglect or exploitation of a person receiving care or services from a provider. C. Applicant's identifying information required. In making the inquiry to the registry prior to employing or contracting with an employee, the provider shall use identifying information concerning the individual under consideration for			

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A 016	Continued From page 3 employment or contracting sufficient to reasonably and completely search the registry, including the name, address, date of birth, social security number, and other appropriate identifying information required by the registry. D. Documentation of inquiry to registry. The provider shall maintain documentation in the employee's personnel or employment records that evidences the fact that the provider made an inquiry to the registry concerning that employee prior to employment. Such documentation must include evidence, based on the response to such inquiry received from the custodian by the provider, that the employee was not listed on there registry as having a substantiated registry-referred incident of abuse, neglect or exploitation. E. Documentation for other staff. With respect to all employed or contracted individuals providing direct care who are licensed health care professionals or certified nurse aides, the provider shall maintain documentation reflecting the individual's current licensure as a health care professional or current certification as a nurse aide. F. Consequences of noncompliance. The department or other governmental agency having regulatory enforcement authority over a provider may sanction a provider in accordance with applicable law if the provider fails to make an appropriate and timely inquiry of the registry, or fails to maintain evidence of such inquiry, in connection with the hiring or contracting of an employee; or for employing or contracting any person to work as an employee who is listed on the registry. Such sanctions may include a directed plan of correction, civil monetary penalty not to exceed five thousand dollars (\$5000) per instance, or termination or non-renewal of any contract with the department or other	A 016		

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A 016	Continued From page 4 governmental agency. [7.1.12.8 NMAC - N, 01/01/2006] 7.1.9.8 CAREGIVER AND HOSPITAL CAREGIVER EMPLOYMENT REQUIREMENTS: A. General: The responsibility for compliance with the requirements of the act applies to both the care provider and to all applicants, caregivers and hospital caregivers. All applicants for employment to whom an offer of employment is made or caregivers and hospital caregivers employed by or contracted to a care provider must consent to a nationwide and statewide criminal history screening, as described in Subsections D, E and F of this section, upon offer of employment or at the time of entering into a contractual relationship with the care provider. Care providers shall submit all fees and pertinent application information for all applicants, caregivers or hospital caregivers as described in Subsections D, E and F of this section. Pursuant to Section 29-17-5 NMSA 1978 (Amended) of the act, a care provider 's failure to comply is grounds for the state agency having enforcement authority with respect to the care provider] to impose appropriate administrative sanctions and penalties. B. Exception: A caregiver or hospital caregiver applying for employment or contracting services with a care provider within twelve (12) months of the caregiver 's or hospital caregiver ' s most recent nationwide criminal history screening which list no disqualifying convictions shall only apply for a statewide criminal history screening upon offer of employment or at the time of entering into a contractual relationship with the care provider. At the discretion of the care provider a nationwide criminal history screening, additional to the required statewide criminal history screening, may be requested.	A 016		

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A 016	Continued From page 5 C. Conditional Employment: Applicants, caregivers, and hospital caregivers who have submitted all completed documents and paid all applicable fees for a nationwide and statewide criminal history screening may be deemed to have conditional supervised employment pending receipt of written notice given by the department as to whether the applicant, caregiver or hospital caregiver has a disqualifying conviction. D. Application: In order for a nationwide criminal history record to be obtained and processed, the following shall be submitted to the department on forms provided by the department. (1) A form containing personal identification which has a photograph of the person and which meets the requirements for employment eligibility in accordance with the immigration and nationality act as amended. A reasonable xerographic copy of a drivers license photograph will suffice under Subsection D of 7.1.9.8 NMAC. (2) A signed authorization for release of information form. (3) Three (3) complete sets of readable fingerprint cards or other department approved media acceptable to the department of public safety and the federal bureau of investigation submitted using black ink. (4) The fee specified by the department for the nationwide and statewide criminal history screening investigation shall not exceed seventy-four (\$74) dollars. Of which, twenty-four (\$24) dollars shall be applied for the federal bureau of investigation nationwide criminal history screening, seven (\$7) dollars shall be applied for the statewide criminal history screening. The remaining application fee shall be applied to cover costs incurred by the department to support activities required by the act and these rules. The fees will not be applied to any other	A 016			

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A 016	Continued From page 6 activity or expense undertaken by the department. (5) If the applicant, caregiver or hospital caregiver must submit another readable set of fingerprint cards upon notice that the fingerprint cards previously submitted were found unreadable, as determined by the federal bureau of investigation or department of public safety, the submission of a second set of fingerprint cards is required, a separate fee will not be charged. A fee shall be charged for submission of a third and subsequent fingerprint sets. (6) If the applicant, caregiver or hospital caregiver has a physical or medical condition which prevents the applicant, caregiver or hospital caregiver from producing readable fingerprints using commonly available fingerprinting techniques, the applicant, caregiver or hospital caregiver shall submit the fingerprint cards with a notarized affidavit signed by the applicant, caregiver, hospital caregiver, returned to the department within fourteen (14) calendar days, as determined by the postmark, which provides: (a) identification of the applicant, caregiver or hospital caregiver; and (b) an explanation of, or a statement describing, the applicant ' s, caregiver ' s or hospital caregiver ' s good faith efforts to supply readable fingerprints; and (c) the physical or medical reason that prevents the applicant, caregiver or hospital caregiver from producing readable fingerprints using commonly available fingerprinting techniques; (d) an applicant, caregiver or hospital caregiver meeting the conditions of this paragraph and who has resided in the state of New Mexico for less than ten (10) years must also submit a ten (10) year work history in	A 016		

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A 016	Continued From page 7 addition to the required affidavits. (7) All documentation submitted to the department for the purposes of criminal history screening and for the purposes set forth in 7.1.9.9 NMAC and 7.1.9.10 NMAC shall become the sole property of the department with the exception of fingerprint cards which shall be destroyed upon clearance by both the federal bureau of investigation and department of public safety. All other submitted documentation shall be retained by the department for a period of one year from the final date of closure and thereafter shall be archived. E. Fees: The federal bureau of investigation has a mandatory processing fee with no exceptions. The department and department of public safety impose a state processing and administrative fee. The fee payment must accompany the fingerprint application, or otherwise be credited to the department prior to or at the same time with the department's receipt of the application documents. The manner of payment of the fee is by bank cashier check or money order payable to the New Mexico department of health or other method of funds transfer acceptable to the department. Business checks will be accepted unless the business tendering the check has previously tendered a check to the department unsupported by sufficient funds. Neither cash nor personal checks will be accepted. The fee may be paid by the care provider or by the applicant, caregiver or hospital caregiver. The department will set a fee in addition to the fees imposed by department of public safety and the federal bureau of investigation that will fully and completely cover costs incurred by the department to support activities required by the act and these rules. The fees will not be applied to any other activity or expense undertaken by the	A 016		

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A 016	Continued From page 8 department. F. Timely Submission: Care providers shall submit all fees and pertinent application information for all individuals who meet the definition of an applicant, caregiver or hospital caregiver as described in Subsections B, D and K of 7.1.9.7 NMAC, no later than twenty (20) calendar days from the first day of employment or effective date of a contractual relationship with the care provider. G. Maintenance of Records: Care providers shall maintain documentation relating to all employees and contractors evidencing compliance with the act and these rules. (1) During the term of employment, care providers shall maintain evidence of each applicant, caregiver or hospital caregiver ' s clearance, pending reconsideration, or disqualification. (2) Care providers shall maintain documented evidence showing the basis for any determination by the care provider that an employee or contractor performs job functions that do not fall within the scope of the requirement for nationwide or statewide criminal history screening. A memorandum in an employee ' s file stating "This employee does not provide direct care or have routine unsupervised physical or financial access to care recipients served by [name of care provider]," together with the employee ' s job description, shall suffice for record keeping purposes. [7.1.9.8 NMAC - Rp, 7.1.9.8 NMAC, 01/01/06] 7.8.2.16 B (3 & 7) Based on record review and interview, the facility failed to ensure that:	A 016		

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A 016	Continued From page 9 1. There was documentation of the Direct Care Staff (DCS) being cleared by the Employee Abuse Registry (EAR) prior to hire. 2. Fingerprint and background checks for the Direct Care Staff (DCS) were being submitted through the New Mexico Department of Health (NMDOH) Caregiver's Criminal History Screening Program (CCHSP) within 20-days of hire. These deficient practices could likely have a negative effect on the safety and welfare of the 11 (R #s 1-11) Assisted Living (AL) and Memory Care Unit (MCU) residents identified on the census provided by the Administrator on 03/09/22, if they are being provided care by staff who have previous disqualifying convictions or who have a previous history of abusing, neglecting, and/or exploiting residents. The findings are: Findings related to EAR clearances: A. Record review of DCS #1's employee file (date of hire 07/02/18), revealed no documentation from NMDOH verifying they were cleared by the EAR prior to hire. B. Record review of DCS #2's employee file (date of hire 11/06/21), revealed no documentation from NMDOH verifying they were cleared by the EAR prior to hire. C. Record review of DCS # 3's employee file (date of hire 08/09/21), revealed no documentation from NMDOH verifying they were cleared by the EAR prior to hire. D. Record review of DCS #4's employee file (date of hire 03/09/15), revealed no documentation from NMDOH verifying they were	A 016	<u>A 016</u> In 3/22, the Pueblo of Isleta (POI) Human Resource Department added the Employee Abuse Registry (EAR) Check to the existing Background Check Procedure. All current employees were cleared through the registry prior to the end of March 2022 and all new hires have been screened through the EAR prior to hire. The HR Director will continue to ensure all new employees are cleared through the Employee Abuse Registry prior to hire per policy. Upon the receipt of the DOH Survey Report on 7/1/22 the Governor's Office is submitting a request for a Waiver/Variance as the POI Fingerprint and Background check process is comprehensive and is considered comparable to the CCHSP process. The POI process includes additional background data not available through the CCHSP process.		

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A 016	Continued From page 10 cleared by the EAR prior to hire. Findings related to Fingerprint and Background checks: E. Record review of DCS #1's employee file (date of hire 07/02/18), revealed no documentation of having been cleared for employment through CCHSP. F. Record review of DCS #2's employee file (date of hire 11/06/21), revealed, no documentation of having been cleared for employment through CCHSP. G. Record review of DCS # 3's employee file (date of hire 08/09/21), revealed no documentation of having been cleared for employment through CCHSP. H. Record review of DCS #4's employee file (date of hire 03/09/15), revealed no documentation of having been cleared for employment through CCHSP. I. On 04/08/22 at 11:30 am, during an interview with the Administrator, she confirmed that she was not sure if the CCHSP clearances for DCSs were done through the NMDOH CCHSP, but she believed the EAR clearances were. She also stated that the Human Resources department is responsible for conducting the EAR and background checks for all new employees. J. On 04/11/22 at 2:52 pm, during an interview with the Human Resources Administrator, she confirmed that: 1. The EAR and background checks were done by a third-party company.	A 016		

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A 016	Continued From page 11 2. The third-party company did not provide the documentation showing when the EAR checks were completed. She stated that she does not know who the third-party company used for fingerprinting services or if it was submitted to CCHSP.	A 016		
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. 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:	A 033		

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A 033	Continued From page 12 (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 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;	A 033		

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NAME OF PROVIDER OR SUPPLIER PUEBLO OF ISLETA ASSISTED LIVING & MEM CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 1001 & 1003 TRIBAL RD #140 ISLETA, NM 87022		
(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 033	Continued From page 13 (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; 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	A 033		

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A 033	Continued From page 14 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 (4) Based on observation and interview, the facility failed to ensure that a safe environment was maintained by storing sharp knives in a secured drawer where they are not accessible to the Assisted Living (AL) and Memory Care Unit (MCU) residents. These deficient practices could likely result in the 11 (R #s 1-11) AL and MCU residents identified on the resident census list provided by the Administrator on 03/09/22, to be at risk of harm, injury, or death if residents have access to unsecured, sharp knives and injure themselves or others. The findings are: A. On 03/09/22 at 9:33 am, during observation of the MCU kitchen, an unsecured drawer containing sharp kitchen knives was observed. The kitchen was unlocked and the residents had access to the kitchen. B. On 03/10/22 at 8:52 am, during observation of the AL kitchen, an unsecured drawer containing sharp kitchen knives was observed. The kitchen was unlocked and the residents had access to the kitchen. C. On 03/11/22 at 9:41 am, during an interview with the Administrator, she confirmed there were sharp kitchen knives in unsecured drawers in the	A 033	<u>A 033</u> Administrator substantiated that at the time of the survey the Kitchen had a drawer containing sharp knives used by the cook that may be accessed by residents. Immediately while surveyors were on site, the knives were placed in a plastic container and placed in a wall cabinet at a height unreachable by residents. A vendor was hired and a lock was installed on 4/7/22 on the drawer (see Attachment A -Picture). Office staff with conduct twice daily check after meals and document locked drawers on kitchen compliance form.	

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A 033	Continued From page 15 MCU and AL kitchens and that the kitchen was unlocked and the residents had access to the knives in the unlocked drawer.	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 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.	A 034		

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A 034	Continued From page 16 (5) A resident may be permitted to keep his or her own medication in a locked compartment in his or her room for self-administration, if the physician's order deems it appropriate. (6) The facility shall not require the residents to purchase medications from any particular pharmacy. (7) Medical gases (oxygen) and equipment used for the administration of inhalation therapy and for resuscitative purposes shall comply with the national fire protection association (NFPA) 99. (8) A proof of use record shall be maintained separately for each schedule II through IV drug (controlled substances). The proof of use sheet shall document: (a) the type and strength of the schedule II through IV drugs; (b) the date and time staff assisted with self-administration; (c) the resident 's name; (d) the prescriber 's name; (e) the dose; (f) the signature of the person assisting with delivery of the medication; and (g) the balance of medication remaining. (9) Any remaining medication discontinued by a physician 's order, or upon discharge or death of the resident shall be inventoried and moved to a separate locked storage container. Such discontinued medications shall be destroyed upon the next quarterly visit by the consulting pharmacist in accordance with 16.19.11.10 NMAC. (10) The record of medication destruction shall be signed by the administrator or designee and the pharmacist and shall be kept on file at the facility. B. Consulting pharmacist. The facility shall maintain records demonstrating that the	A 034		

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A 034	Continued From page 17 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) 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	A 034		

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A 034	Continued From page 18 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 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)	A 034		

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A 034	Continued From page 19 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. 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: 1. All physician ordered medications for residents were available for use. 2. Oxygen cylinder tanks were stored securely and protected from accidental damage.	A 034		

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A 034	Continued From page 20 These deficient practices could likely result in the 11 (R #s 1-11) Assisted Living (AL) and Memory Care Unit (MCU) residents identified on the resident census list provided by the Administrator on 03/09/22, to be at risk of harm, injury, or death if: 1. Residents were to miss doses or treatments because the medications prescribed by the physicians were not available. 2. 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 tanks act like missiles and hit a resident/staff/rescuer during a fire. The Findings are: Findings related to medication A. Record review of R #1's Medical Administrative Record (MAR) dated 07/01/21 through 07/31/21, revealed the following medications were initiated on the MAR as given: a. On 07/02/21, 07/03/21 and 07/05/21, DCS #8 initiated MAR.	A 034		

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A 034	Continued From page 21 b. On 07/04/21, FDCS #9 initialed MAR. c. On 07/06/21 and 07/07/21, MAR was marked "O" with a line through it, for out of medicine (O). [REDACTED] a. On 07/02/21, 07/03/21 and 07/05/21, DCS #8 initialed MAR. b. On 07/04/21, FDCS #9 initialed the MAR. c. On 07/06/21 and 07/07/21, MAR was marked O. [REDACTED] a. On 07/02/21, 07/03/21, and 07/05/21, DCS #8 initialed MAR. b. On 07/04/21, FDCS #9 initialed MAR. c. On 07/06/21 and 07/07/21, MAR was marked O. [REDACTED] a. On 07/01/21 (8:00 am dose), DCS #1 initialed MAR. b. On 07/02/21, 07/03/21, 07/05/21, and 07/06/21 (8:00am dose), DCS #8 initialed MAR. c. On 07/02/21 and 07/04/21 (6:00 pm dose), FDCS #10 initialed MAR. d. On 07/04/21 (8:00 am dose), FDCS#9 initialed MAR. e. On 07/05/21 and 07/06/21 (6:00 pm dose), FDCS #11 initialed MAR. [REDACTED] a. On 07/02/21 - 07/04/21, FDCS #10 initialed MAR. b. On 07/05/21 and 07/06/21, FDCS #11 initialed MAR. [REDACTED] a. On 07/02/21-07/04/21, 07/07/21, 07/09- 07/11/21, 07/14/21, and 07/15/21, FDCS #10 initialed MAR.	A 034		

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A 034	Continued From page 22 b. On 07/05/21, 07/06/21, 07/08/21, 07/12/21, and 07/13/21, FDOS #11 initialed MAR. B. A record review of R #6's MAR dated 07/01/21 through 07/31/21, revealed the following medications were marked as unavailable (O) and there is no documentation or report to prescriber as follows: [REDACTED] a. On 07/02/21 and 07/03/21 B. On 03/24/22 at 2:01 pm, during an interview with R #1's two (2) co-guardians, they revealed that: 1. On 07/16/21, when a guardian picked up R #1 for a doctor appointment, she requested R #1's medication to take to the doctor's appointment. Upon review of the medication bubble packs she identified that many medications had not been administered for previous dates. 2. R #1's Primary Care Physician (PCP) reviewed the medication bubble packs and confirmed that medications were missed. 3. The guardian said that R #1 had been having bad headaches and the PCP said she wasn't surprised because her meds were missed and she was concerned about the effects that the missed medications would have on R #1. C. On 04/07/22 at 1:03 pm, during interview with the Pharmacist, she confirmed that R #1's hypertension medication, Metoprolol Tartrate 25 mg 1/2 tab PO two times daily (BID), was a 30-day fill and it hadn't been filled until the day the guardian raised concerns (07/16/21), when it should have been filled on 07/02/21, indicating that it was missed for at least 14 days. D. On 04/08/22 at 3:34 pm, during an interview	A 034	not according to ALF MAR July 6 + 7th July 8 0 1	

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A 034 *	Continued From page 23 with R #1's PCP, she reviewed R #1 medications and confirmed that: 1. On 07/16/21, she had an appointment with R #1 and [REDACTED] guardian revealed various bubble packs containing medications that should have been taken, but were missed. The PCP became concerned that R #1 was not receiving the medications ordered for [REDACTED] and she was concerned that medications were given intermittently and for long periods of time and this could put [REDACTED] health at risk. 2. She confirmed that following her review of R #1's medications, the following medication Rx's for R #1 were filled and/or picked up late (post running out of medications from previous prescription fill), and it resulted in R #1 missing the medications for the same period of time: [REDACTED]	A 034		

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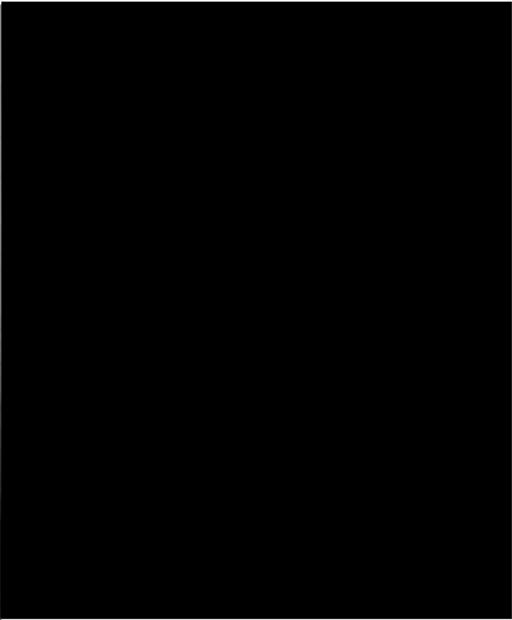
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NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

PUEBLO OF ISLETA ASSISTED LIVING & MEM CARE

1001 & 1003 TRIBAL RD #140
ISLETA, NM 87022

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A 034 6 1 4 a	Continued From page 24  G. On 04/08/22 at 11:30 am, during an interview with the Administrator, she confirmed that sometimes R #1's medications were missed, and that R #1 did not always receive her medications according to doctor's orders. H. On 04/08/22 at 4:00 pm, during an interview with DCS #1, she confirmed that in July of 2021, they were always running out of medications for residents and: 1. Sometimes they would be out of medications for a week. 2. That recently, R #7 was out of  medications for 1-2 weeks and  told her  felt like  was going to have a breakdown. I. On 04/11/22 at 1:13 pm, during an interview	A 034		

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A 034	Continued From page 25 with DCS #8, she confirmed that in 2021, they always ran out of medications. Findings related to oxygen J. On 03/10/22 at 11:17 am, during observation of the Assisted Living (AL) oxygen storage room, four unsecured oxygen cylinder tanks were observed. K. On 04/08/22 at 11:30 am, during an interview with the Administrator, she confirmed there were four unsecured oxygen tanks being stored in the oxygen storage room.	A 034	<u>A 034</u> All staff involved in reported medication deficiencies are no longer employed by the Assisted Living Facility. A part time RN was hired in November of 2022, with direct responsibility for overseeing the medication program, along with the Regulatory Monitor, Administrator and Consulting pharmacist. RN is involved in all admissions and conducts, in addition, monthly audits to ensure medications are being managed, refilled, and provided per physician orders. In addition, Medication Management Procedures outlining the entire medication process and handling to include physician orders, refills, medication pick up, medication assistance, documentation, discontinuation, and destruction of medication was created and implemented in May 2021. On 5/10/21 Medication Management Procedures were put in place by current by new Administration. On 2/3/22 Facility held a mandatory training regarding Medication Assistance for all staff involved in Medication Assistance as well as a refresher course in 5/22. Per policy, the course will be provided annually per regulations, refreshers as needed, as well as at orientation for all new employees. No residents at the time of the DOH Survey were prescribed oxygen. On 4/20/22 Regulatory Monitor requested pickup from oxygen supplier. Any remaining cylinders were placed in approved oxygen storage stands to avoid falling over and causing damage. The on-duty medication assist staff member will be responsible for daily check to ensure oxygen cylinders are properly stored.		
A 035	7 NMAC 8.2.35 Medication MEDICATIONS: Administration of medications or staff assistance with self-administration of medications shall be in accordance with state and federal laws. No medications, including over-the-counter medications, PRN (when needed) medications, or treatment shall be started, changed or discontinued by the facility without an order from the physician, physician assistant or nurse practitioner and with entry into the resident's record. A. State board of nursing licensed or certified health care professionals are responsible for the administration of medications. Administration may only be performed by these individuals. B. Facility staff may assist a resident with the self-administration of medications if written consent by the resident is given to the administrator of the facility or the administrator's designee. If the resident is incapable of giving consent, the surrogate decision maker named in accordance with New Mexico law may give	A 035			

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A 035	Continued From page 26 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 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	A 035	<u>A 035</u> Since hire in 11/22, RN is responsible for MAR reconciliation at admission to ensure all are required information is included on the MAR per NMAC 7.8.2.35. POI Assisted Living is contracted with a Consulting Pharmacist and receives quarterly pharmacy reviews. The most recent review conducted in 6/22, revealed no deficiencies on the MAR. RN is involved in all admissions and conducts, in addition, monthly audits to ensure medications are being managed, refilled, and provided per physician orders. To ensure compliance, RN will continue current process of reconciliation and monthly audits.	

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A 035	Continued From page 27 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 (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	A 035		

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A 035	Continued From page 28 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 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]	A 035		

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A 035	Continued From page 29 This REQUIREMENT is not met as evidenced by: 7.8.2.35 G (2-5,16, 19) I Based on record review and interview the facility failed to ensure for 4 (R #s 1-3 & 6) of 4 (R #s 1-3 & 6) residents whose Medication Administrative Records (MARs) were reviewed for compliance, were accurate, current, and included all required information included: 1. Any known allergies to medication the resident has. 2. Name of the resident's Primary Care Physician (PCP). 3. Diagnosis or reason for the medication. 4. The name of the medication, including both brand and generic names. 5. Initials of person assisting with or administering medications. 6. Any missed dose of medication. 7. Documentation of refused medications and of report to the prescriber. This deficient practice could likely result in the residents being at risk of harm or death if Direct Care Staff (DCS) do not: 1. Know what allergies the resident has. 2. Know who the resident's PCP is. 3. The reason for the medication. 4. Document both brand and generic names for medications. 5. Initials of person assisting with or administering medications 6. Document missed medications. 7. Document refused medications and of report to the prescriber. The findings are:	A 035		



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A 035	Continued From page 30 R #1's findings A. Record review of R #1's MAR dated 07/01/21 through 07/31/21, revealed that: 1. Any known or unknown allergies to all medications were not listed on the MAR. 2. The name of the PCP was not listed on the MAR. 3. The diagnosis and reason for the following medications was missing: 4. The brand names were missing for all medications. 5. The initials were missing on the MAR, and there was no documentation of missed, refused or unavailable medications, or report of notification to PCP for the following:	A 035			

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A 035	Continued From page 31 1) On 07/01/21, 6:00 pm dose, MAR was not initialed. 2) On 07/30/21, 6:00 pm dose, MAR was not initialed. [REDACTED] 1) On 07/01/21, MAR was not initialed. 2) On 07/17/21, MAR was not initialed. 3) On 07/18/21, MAR was scratched out and made illegible. [REDACTED] 1) On 07/01/21, MAR was not initialed. 2) On 07/30/21, MAR was not initialed. [REDACTED] 1) On 07/30/21, MAR was not initialed. R #2's findings B. Record review of R #2's MAR dated 07/01/21 - 07/31/21 revealed that: 1. The brand names were missing for all medications. 2. Initials were missing and no documentation that medications were administered for: a) Memantine 10 mg (dementia), 6:00 pm dose on 07/01/21 C. Record review of R #2's MAR dated 03/01/22 - 03/15/22 revealed that: 1. The brand names were missing for all medications. 2. Initials were missing and no documentation for: [REDACTED] 1) On 03/02/22 - 03/05/22, 8:00 am 2) On 03/07/22 - 03/12/22, 8:00 am 3) On 03/13/22 - 03/15/22, 6:00 pm 4) On 03/14/22 - 03/15/22, 8:00 am	A 035		

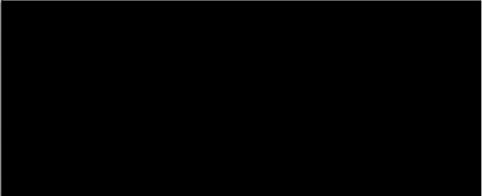
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A 035	Continued From page 32 R #3's findings D. Record review of R #3's MAR dated 07/01/21 - 07/31/21 revealed that: 1. The diagnosis or reason for medication use was missing for [REDACTED] 2. The brand names were missing for all medications. 3. Initials were missing and no documentation that medications were administered for: [REDACTED] E. Record review of R #3's MAR dated 03/01/22 - 03/15/22 revealed that: 1. The brand names were missing for all medications. 2. Initials were missing and no documentation that medications were administered for: [REDACTED] R #6's findings F. Record review of R # 6's 07/01/21 - 07/31 21 MAR revealed the following: 1. That it did not include the diagnosis or reason for the following medications: [REDACTED]	A 035		

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A 035	Continued From page 33 	A 035			

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A 035	Continued From page 34  G. Record review of Complaint Intake #55381 dated 11/03/21, revealed that the complainant reported medications were being signed as given to R #1, however, the bubble packs show that they were not given. H. On 03/24/22 at 2:01 pm, during an interview with both of R #1's guardians, they reported that: 1. Some of R #1's medications were missed, some had never been opened, and the medications had not been reconciled. 2. A guardian had took the log of medications R #1 was taking and the pre-packaged bubble packs from the facility to a 07/16/21 doctor appointment with R #1 and [REDACTED] PCP. 3. The PCP confirmed that medications were not being filled on time and medications were missed. 4. The PCP was concerned, and she contacted the Managing Pharmacist (Pharmacist) at POI Health Center Pharmacy, who also confirmed that R #1's medications weren't being filled on time and medications were missed. 5. A guardian stated that she had photographic evidence of the bubble packs and the reconciliation log she took from the facility, and she said that she would forward them to surveyor. I. On 03/24/22 at 3:48 pm, Surveyor called R #1's guardian's cell phone and left a message for [REDACTED] to call Surveyor to provide [REDACTED] email address in order for Surveyor to send [REDACTED] the encrypted email address for her evidentiary photographs	A 035			

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A 035	Continued From page 35 and documents she had offered during her interview J. On 03/24/22 at 4:04 pm, Surveyor called R #1's guardian's cell phone and left a message for [REDACTED] to call or to text Surveyor to provide [REDACTED] email address in order for Surveyor to send her the encrypted email address for her evidentiary photographs and documents she had offered during her interview K. On 04/06/22 at 10:18 am, during an interview with the Registered Nurse (RN), she stated that she manages all MARs. 1. RN confirmed that prior to her working at the ALF, direct care staff (DCS) and med techs had not completed MARs correctly for discontinued medications or change in medications and since January 2022, she has trained them on appropriate notation for MARs. 2. RN confirmed that sometimes medications are missed and the caregivers forget to annotate what occurred. L. On 04/07/22 at 1:03pm, during an interview with the Pharmacist, she confirmed that various medications for R #1 were missed, and that 1. DCS were not following normal protocols when filling medications as follows: a. Medications should be called in as 30-day fills at the same time, per resident, every month. b. The facility was filling medications as they ran out of them, and by the time they were filled, they were already late, so medications were being missed. 3. On 07/16/21, R #1's guardian took various medicine bubble-packs to R #1's doctor's appointment: a. There were ten (10) types of medications prescribed to R #1	A 035			

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A 035	Continued From page 36 b. The Pharmacist and PCP decided to consolidate the 10 medications into 2 bubble packs. c. The Pharmacist filled in gaps for medications that were missing and destroyed all overflow medications to establish a baseline for R #1, but she did not complete a reconciliation report to show what was destroyed and what had been missing. d. The Pharmacist confirmed that R #1's hypertension medication, Metoprolol Tartrate 25 mg 1/2 tab PO two times daily (BID), was a 30-day fill and it hadn't been filled until the day the guardian raised concerns (07/16/21), when it should have been filled on 07/02/21, indicating that it was missed for at least 14 days. M. On 04/08/22 at 3:34 pm, during an interview with R #1's PCP, she reviewed R #1 medications and confirmed that: 1. On 07/16/21, she had an appointment with R #1 and [REDACTED] guardian revealed various bubble packs containing medications that should have been taken, but were missed. The PCP became concerned that R #1 was not receiving the medications ordered for her and she was concerned that medications were given intermittently and for long periods of time and this could put her health at risk. 2. She confirmed that following her review of R #1's medications, the following medication Rx's for R #1 were filled and/or picked up late (post running out of medications from previous prescription fill), and it resulted in R #1 missing the medications for the same period of time: [REDACTED] 1) On 03/01/21, Rx was filled 5 days late 2) On 04/22/21, Rx was filled 22 days late 3) On 06/02/21, Rx was filled 12 days late 4) On 07/06/21, Rx was filled 4 days late	A 035		

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A 035	Continued From page 37 [REDACTED] 1) On 03/01/21, Rx was filled 5 days late 2) On 04/22/21, Rx was filled 22 days late 3) On 06/02/21, Rx was filled 12 days late 4) On 07/06/21, Rx was filled 5 days late [REDACTED] 1) On 03/01/21, Rx was filled 5 days late 2) On 04/22/21, Rx was filled 22 days late 3) On 06/02/21, Rx was filled 12 days late 4) On 07/06/21, Rx was filled 4 days late [REDACTED] 1) On 03/01/21, Rx was filled 6 days late 2) On 04/22/21, Rx was filled 31 days late 3) On 06/02/21, Rx was filled 23 days late 4) On 07/06/21, Rx was filled 4 days late [REDACTED] 1) On 03/02/21, Rx was filled 39 days late 2) On 05/13/21, Rx was filled 41 days late 3) On 07/06/21, Rx was filled 23 days late [REDACTED] 1) On 02/01/21, Rx was filled 10 days late 2) On 03/29/21, Rx was filled 28 days late 3) On 05/13/21, Rx was filled 45 days late 4) On 07/06/21, Rx was filled 23 days late [REDACTED] 1) On 03/01/21, Rx was filled 4 days late 2) On 04/22/21, Rx was filled 21 days late 3) On 06/02/21, Rx was filled 11 days late 4) On 07/06/21, Rx was filled 4 days late [REDACTED] 1) On 01/11/21, Rx was filled 4 days late 2) On 02/16/21, Rx was filled 4 days late 3) On 04/09/21, Rx was filled 24 days late 4) On 05/20/21, Rx was filled 11 days late 5) On 07/09/21, Rx was filled 19 days late	A 035		

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STATE FORM

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A 035	Continued From page 38 N. On 04/08/22 at 11:30 am, during an interview with Administrator, she acknowledged that sometimes R #1's medications were missing and she confirmed that one time a medication certified person did not give meds out. O. On 04/08/22 at 4:00 pm, during an interview with DCS #1, she confirmed that in July of 2021, they were always running out of medications for residents and: 1. Sometimes they would be out of medications for a week. 2. That recently R #7 was out of [REDACTED] for 1-2 weeks and [REDACTED] told her [REDACTED] felt like [REDACTED] was going to have a breakdown. P. On 04/11/22 at 1:13 pm, during an interview with DCS #8, she confirmed that in 2021, they always ran out of medications. Q. On 04/22/22 at 3:44 pm, in an interview with RN, she confirmed that: 1. Known allergies and medications were omitted from MAR until the last two months. 2. The contracted pharmacist who reviews their medications quarterly directed the staff to add brand names as well as generics to MARs, but the facility's medical director directed staff to omit brand names from MARs. 3. DCS often forget to document blank/non-initialed MARs or any missed dose of medication, including refused medications.	A 035		
A 038	7 NMAC 8.2.38 Housekeeping Services HOUSEKEEPING SERVICES. The facility shall maintain the interior and exterior of the facility in a	A 038		

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A 038	Continued From page 39 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, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.38 C Based on observation and interview, the facility failed to ensure that poisonous or flammable substances were not stored in residential, food preparation, or food storage areas and were not accessible to residents. This deficient practice could likely result in harm to the 11 (R #s 1-11) Assisted Living (AL) and Memory Care Unit (MCU) residents listed on the resident census provided by the Administrator on 03/09/22 if the residents were to spill or ingest/swallow poisonous chemicals. The findings are:	A 038	<u>A 038</u> All Chemicals were properly stored. On 4/14/22 locks were installed on all cabinets containing kitchen sanitizing chemicals. Office staff with conduct twice daily checks after meals and document locked drawers on kitchen compliance form.	

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A 038	Continued From page 40 A. On 03/09/22 at 9:15 am, during an observation of the MCU kitchen, the following chemicals were observed in unlocked cabinets: 1. In the cabinet under the kitchen sink: a. One 23-ounce bottle of germicidal cleaner. b. Three 32-ounce bottles of oven cleaner. c. One gallon of dishwashing detergent. d. One gallon of bleach. e. One 5-gallon bucket of rinse additive. f. One 32-ounce bottle of disinfectant. g. One quart of bathroom cleaner. h. One 19-ounce can of furniture polish. i. Two gallons of dishwashing detergent. 2. In the cabinet under the dishwashing sink: a. One 26-ounce bottle of an unknown chemical. b. Two 23-ounce bottle of germicidal cleaner. c. One 32-ounce bottle of pot and pan detergent. d. One 32-ounce bottle of oven cleaner. B. On 03/10/22 at 8:49 am, during observation of the AL kitchen, the following chemicals were observed in unlocked cabinets: 1. In the cabinet under the handwashing sink: a. One 23-ounce bottle of germicidal cleaner. b. One gallon of germicidal bleach. c. One 26-ounce bottle of bleach water. 2. In the cabinet under the kitchen sink: a. Two gallons of dishwashing detergent. b. One 15-ounce can of stainless steel cleaner. c. One 32-ounce bottle of oven cleaner. d. One 32-ounce bottle of pot and pan	A 038		

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A 038	Continued From page 41 detergent. C. On 03/11/22 at 9:41 am, during an interview with the Administrator, she confirmed there were unsecured chemicals in unlocked cabinets in the MCU and AL units that were accessible to residents.	A 038		
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 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	A 045	<u>A 045</u> On 4/20/22, Regulatory Monitor requested Public Works check hot water temperatures in kitchen, laundry, and all resident care areas. All Temperatures were determined to be within regulations. Public Works is scheduled to perform quarterly water temperature checks and provide documentation to Regulatory Monitor. This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, the Pueblo of Isleta Assisted Living and Memory Care does not admit that the deficiency listed on this form exist, nor does the facility admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiency. The facility enter reserves the right to challenge in legal and/or regulatory or administrative proceedings the deficiency, statements, facts, and conclusions that form the basis for the deficiency. Please accept this plan of correction as the facility credible allegation of compliance with the certification requirements established in NMAC 7.8.2.12	

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A 045	Continued From page 42 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 the bathroom hot water temperatures were maintained at a maximum of 110 degrees Fahrenheit (F). This deficient could likely result in the 11 (R #s 1-11) Assisted Living (AL) and Memory Care Unit (MCU) residents listed on the census list provided by Administrator on 03/09/22, to be at risk of being burned by water that is too hot. The findings are: A. On 03/14/22 at 10:00 am, during an observation of R #4's room #208, the water temperature was found to be at 129.5-degrees Fahrenheit. B. On 04/08/22 at 11:30 am, during an interview with the Administrator, she confirmed the findings regarding the water temperature being 129.5-degrees Fahrenheit in R #4's room #208.	A 045		
A 069	7 NMAC 8.2.69 Memory Care Units MEMORY CARE UNITS: An assisted living facility that provides a memory care unit to serve residents with dementia shall comply with the provisions of subsection A-J below in addition to the rules applicable to all assisted living facilities,	A 069		

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A 069	Continued From page 43 7.8.2 NMAC. A. Additional definitions: The following definitions, in addition to those in 7.8.2.7 NMAC, shall apply. (1) " Alzheimer ' s " means a brain disorder that destroys brain cells, causing problems with memory, thinking and behavior that are severe enough to affect work, lifelong hobbies or social life. Alzheimer ' s gets progressively worse and is fatal. (2) " Care coordination agreement requirement " means a written document that outlines the care and services that are provided by other outside agencies for assisted living residents that require additional care and services. (3) " Dementia " means loss of memory and other mental abilities severe enough to interfere with daily life. It is caused by changes in the brain. (4) " Memory care unit " means an assisted living facility or part of or an assisted living facility that provides added security, enhanced programming and staffing appropriate for residents with a diagnosis of dementia, Alzheimer ' s disease or other related disorders causing memory impairments and for residents whose functional needs require a specialized program. (5) " Secured environment " means locked (secured/monitored) doors/fences that restrict access to the public way for residents who require a secure unit. B. Care coordination requirement. An assisted living facility that accepts residents with memory issues shall determine which additional services and care requirements are relevant to the resident and disease process. (1) The medical diagnosis and ISP shall be utilized in the determination of the need for additional services. (2) The assisted living facility shall ensure the	A 069		

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A 069	Continued From page 44 coordination of services and shall have evidence of an agreement of care coordination for all services provided in the facility by an outside health care provider. C. Employee training. In addition to the training requirements for all assisted living facilities, pursuant to 7.8.2.17 NMAC, all employees assisting in providing care for memory unit residents shall have a minimum of twelve (12) hours of training per year related to dementia, Alzheimer ' s disease, or other pertinent information. D. Individual service plan (ISP). An assisted living facility that admits memory care unit residents shall create an ISP in coordination with the resident ' s primary care practitioner, in compliance with the requirements outlined in " Individual Service Plan, " 7.8.2.26 NMAC, pursuant to a team meeting as described in " Exceptions to admission, readmission and retention, " Subsection C of 7.8.2.20 NMAC, and which ensures the following criteria: (1) identification of the resident's needs specific to the memory care unit and the services that are provided; each memory unit resident shall receive the services necessary to meet the individual resident ' s needs; (2) medications shall be self-administered, self-administered with assistance by an individual that has completed a state approved program in medication assistance or administered by the following individuals: (a) a physician; (b) a physician extender (PA or NP); (c) a licensed nurse (RN or LPN); (d) the resident if their PCP has approved it; (e) family or family designee; and (f) any other individual in accordance with applicable state and local laws.	A 069			

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A 069	Continued From page 45 E. Assessments and reevaluations. (1) An assessment shall be completed by a registered nurse or a physician extender within fifteen (15) days prior to admission. When emergency placement is warranted the fifteen (15) day assessment shall be waived and the assessment shall be completed within five (5) days after admission. (a) The resident shall have a medical evaluation and documentation by a physician, physician's assistant or a nurse practitioner within six (6) months of admission. (b) The pre-admission assessment shall include written findings, an evaluation of less restrictive alternatives and the basis for the admission to the secured environment. The written documentation shall include a diagnosis from the resident's PCP of Alzheimer's disease or other dementia and the need for the resident to reside in a memory care unit. (c) Only those residents who require a secured environment placement or whose needs can be met by the facility, as determined by the assessment prior to admission or on review of the individual service plan (ISP), shall be admitted. (2) A re-evaluation must be completed every six (6) months and when there is a significant change in the medical or physical condition of the resident that warrants intervention or different care needs, or when the resident becomes a danger to self or others, to determine whether the resident's stay in the assisted living facility memory care unit is still appropriate. F. Documentation in the resident's record. In addition to the required documentation pursuant to 7.8.2.21 NMAC, the following information shall be documented in the resident's record: (1) the physician's diagnosis for admission to a	A 069			

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A 069	Continued From page 46 secure environment or a memory care unit; (2) the pre-admission assessment; and (3) the re-evaluation(s). G. Secured environment. (1) Memory care unit residents may require a secure environment for their safety. A secured environment is any locked (secured/monitored) area in which doors and fences restrict access to the public way. These include but are not limited to: (a) double alarm systems; (b) gates connected to the fire alarm; and (c) tab alarms for residents at risk for elopement. (2) In addition to the interior common areas required by this rule, the facility shall provide a safe and secure outdoor area for the year round use by the residents. (a) Fencing or other enclosures shall prevent elopement and protect the safety and security of the residents. (b) Residents shall be able to independently access the outdoor areas. (3) Locked areas shall have an access code or key which facility employees shall have available on their person or on the locking unit itself at all times. H. Resident rights. In addition to the requirements pursuant to 7.8.2.32 NMAC, the following shall apply: (1) the resident's rights may be limited as required by their condition and as identified in the ISP; (2) the resident who believes that he or she has been inappropriately admitted to the secured environment may request the facility in contact the resident ' s legal guardian, or an advocate such as the ombudsman or the primary care practitioner; upon request, the facility shall assist the resident in making such contact.	A 069		

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A 069	Continued From page 47 I. Disclosure to residents. A facility that operates a secured environment shall disclose to the resident and the resident's legal representative, if applicable and prior to the resident's admission to the facility, that the facility operates a secured environment. (1) The disclosure shall include information about the types of resident diagnosis or behaviors that the facility provides services for and for which the staff are trained to provide care for. (2) The disclosure shall include information about the care, services and the type of secured environment that the facility and trained staff provide. J. Staffing. The facility shall provide the sufficient number of trained staff members to meet the additional needs of the residents in the secured environment. There must be at least one (1) trained staff member awake and in attendance in the secured environment at all times. [7.8.2.69 NMAC - N, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.69 J Based on record review and interview, the facility failed to ensure that there was a minimum of (1) one Direct Care Staff (DCS) on duty at all times in the Memory Care Unit (MCU). This deficient practice could likely negatively affect the safety and welfare of the 3 (R #s 3, 8, and 10) residents listed as living in the MCU on the resident census list provided by the Administrator on 03/09/22, to be at risk of harm, injury if there are not adequate staffing available to assist residents. The findings are:	A 069	<u>A 069</u> In May of 2021, the scheduling process changed. Since then, the Benefits and Billing Manager creates the schedule 3 weeks in advance with the assistance of shift supervisors. The staffing pattern is 2 care staff scheduled on each 8-hour shift. The shift supervisors are responsible for daily staffing coverage and ensure adequate staffing. The number of beds in Assisted Living is 10 and in Memory Care is 9. The Benefits and Billing Manager will ensure on-going compliance through the scheduling process.	

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A 069	Continued From page 48 A. Record review of complaint NM #50547 dated 03/02/21, revealed there was only one staff working on an unknown date during the week of 02/21/21 to 02/27/21. B. Record review of staff timesheets revealed that on 02/27/21, there was only one Direct Care Staff (DCS) working in the facility during the day from 6:40 am to 6:42 pm for both the Assisted Living (AL) and MCU units. C. On 04/08/22 at 11:30 am, during an interview with the Administrator, she acknowledged that there was only one staff working on 02/27/21 from 6:40 am to 6:42 pm according to the record review of the employee timesheets. She stated she believed the facility was in compliance having one staff with less than 15 residents and that she was not aware that one staff has to be in the secured environment in the MCU at all times.	A 069		