STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	7204	A. BUILDING: _____ B. WING _____	05/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOW MANOR	815 W ADOBE DRIVE DEMING, NM 88030

(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 an Initial Survey completed on 05/16/24 for the state requirements of NMAC 7.8.2, Regulations for Assisted Living Facilities for Adults. Census: [redacted]	A 000		
A 022	7 NMAC 8.2.22 Facility Reports, Records, Rules, Policies FACILITY REPORTS, RECORDS, RULES, POLICIES AND PROCEDURES: A. Reports and records. Each facility shall keep the following reports, records, policies and procedures on file at the facility and make them available for review upon request by the licensing authority, residents, potential residents or their surrogate decision makers: (1) fire inspection report; (2) zoning approval; (3) building official approval (certificate of occupancy); (4) a copy of the approved building plans; (5) a copy of the most recent survey conducted by the licensing authority, to include adverse actions or appeals and complaints; (6) for facilities with food establishments/kitchens that require a permit from the local health authority that has jurisdiction, a copy of the current inspection report in accordance with the applicable, municipal, or federal laws and regulations and pursuant to Subsection B of 7.6.2.8 NMAC, regarding kitchen and food management; if a facility is considered a licensed private home and not required to meet specific requirements by the local health authority, a copy of that determination must also be maintained; (7) where necessary, a copy of the liquid waste disposal and treatment system permit from the	A 022	A 022 As of the submission date of this plan of correction the facility has created an Emergency action plan, including region/area wide disaster preparedness. On 06/13/2024 the facility Administrator conducted an in-service for staff members regarding the updated Emergency Action Plan including region/area disasters. The Emergency Action Plan review is added to the Administrator agenda for review at least once a year. This review is scheduled on the Administrator's agenda(calendar). In addition to the annual review, the plan will also be reviewed following any emergency incident.	06/13/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	7204	A. BUILDING: _____ B. WING _____	05/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOW MANOR	815 W ADOBE DRIVE DEMING, NM 88030

(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 022	Continued From page 1 local health authority that has jurisdiction; (8) thirty (30) days of menus as planned, including snacks and thirty (30) days of menus as served, including snacks; (9) record of monthly fire drills conducted at the facility and the fire safety evaluation system (FSES) rating, if applicable; (10) written emergency plans, policies and procedures for medical emergencies, power failure, fire or natural disaster; plans shall include evacuation, persons to be notified, emergency equipment, evacuation routes, refuge areas and the responsibilities of personnel during emergencies; plans shall also included a list of transportation resources that are immediately available to transport the residents to another location in an emergency; the emergency preparedness plan shall address two types of emergencies: (a) an emergency that affects just the facility; and (b) a region/area wide emergency; (11) a copy of this rule, Requirements for Assisted Living Facilities for Adults, 7.8.2 NMAC); (12) for facilities with two or more residents (that are not related to the owner), a valid custodial drug permit issued by the NM board of pharmacy, that supervise administration and self-administration of medications or safeguards with regard to medications for the residents; and (13) vaccination records for pets in the facility. B. Reports and records. Each facility shall keep the following reports, records, policies and procedures on file at the facility and make them available for review upon request by the licensing authority: (1) a copy of the facility license; (2) employee personnel records, including an application for employment, training records and personnel actions:	A 022		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	7204	A. BUILDING: _____ B. WING _____	05/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOW MANOR	815 W ADOBE DRIVE DEMING, NM 88030

(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 022	Continued From page 2 (a) caregiver criminal history screening documentation pursuant to 7.1.9 NMAC; (b) employee abuse registry documentation pursuant to 7.1.12 NMAC; and (3) a copy of all waivers or variances granted by the licensing authority. C. Rules. Prior to admission to a facility a prospective resident or his or her representative shall be given a copy of the facility rules. Each facility shall have written rules pertaining to resident ' s rights and shall include the following: (1) resident use of tobacco and alcohol; (2) resident use of facility telephone or personal cell phone; (3) resident use of television, radio, stereo and cd; (4) the use and safekeeping of residents ' personal property; (5) meal availability and times; (6) resident use of common areas; (7) accommodation of resident ' s pets; and (8) resident use of electric blankets and appliances. D. Policies and procedures. All facilities shall have written policies and procedures covering the following areas: (1) actions to be taken in case of accidents or emergencies; (2) policy and procedure for updating and consolidating the residents current physician or PCP orders, treatments and diet plans every six (6) months or when a significant change occurs, such as a hospital admission; (3) policy for medication errors; (4) method of staying informed when residents are away from the facility (e.g., sign-out sheets or other record indicating where the resident will be, cell phone contact, etc.); (5) the handling of resident's funds, if the facility	A 022		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	7204	A. BUILDING: _____ B. WING _____	05/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOW MANOR	815 W ADOBE DRIVE DEMING, NM 88030

(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 022	Continued From page 3 provides such services; (6) reporting of incidents, including abuse, neglect and misappropriation of property, injuries of unknown cause, environmental hazards and law enforcement interventions in accordance with 7.1.13 NMAC; (7) reporting and investigating internal complaints; (8) reporting and investigating complaints to the incident management bureau; (9) staff and resident fire and safety training; (10) smoking policy for staff, residents and visitors; (11) the facility's bed hold policy; (12) admission agreement; (13) admission records; (14) resident records including maintenance and record retention if the facility closes; (15) program narrative; (16) resident's rights with regard to making health care decisions and the formulation of advance directives; (17) personnel policies; (18) identifying and safeguarding resident possessions; (19) securing medical assistance if a resident's own physician is not available; (20) staff training appropriate to staff responsibilities; (21) staff training for employees who provide assistance to residents with boarding or alighting from motor vehicles and safe operation of motor vehicles to transport residents; (22) witnessed destruction of unused, outdated or recalled medication by the facility administrator with the consulting pharmacist present; and (23) mealtimes, daily snacks, menus, special diets, resident ' s personal preference for eating alone or in the dining room setting.	A 022		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	7204	A. BUILDING: _____ B. WING _____	05/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOW MANOR	815 W ADOBE DRIVE DEMING, NM 88030

(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 022	Continued From page 4 [7.8.2.22 NMAC - Rp, 7.8.2.23 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.22 A 10 (b) Based on record review and interview, the facility failed to ensure there was a complete written emergency disaster plan in the event of a region/area-wide emergency. This deficient practice could likely result in the [redacted] (R #s [redacted]) residents listed on the census provided by the Administrator on 05/13/24 of being at risk of harm, injury, or death if Direct Care Staff (DCS) and families did not know what to do or where to go if there was a region/area wide emergency disaster which required evacuation. The findings are: A. Record review of the facility's emergency preparedness plan (undated) revealed the emergency preparedness plan did not include evacuation plans for a region/area-wide disaster. B. On 05/14/24 at 1:56 pm, during an interview, the Administrator confirmed the facility's emergency preparedness plan did not include evacuation plans for a region-wide disaster.	A 022		
A 025	7 NMAC 8.2.25 Resident Evaluation	A 025		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	7204	A. BUILDING: _____ B. WING _____	05/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOW MANOR	815 W ADOBE DRIVE DEMING, NM 88030

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 025	Continued From page 5 RESIDENT EVALUATION: A. A resident evaluation shall be completed by an appropriate staff member within fifteen (15) days prior to admission to determine the level of assistance that is needed and if the level of services required by the resident can be met by the facility. B. The initial resident evaluation shall establish a baseline in the resident ' s functional status and thereafter assist with identifying resident changes. The resident evaluation shall be reviewed and updated at a minimum of every six (6) months or when there is a significant change in the resident ' s health status. C. The resident ' s evaluation shall be documented on a resident evaluation form and at a minimum include the following abilities, behaviors or status: (1) activities of daily living; (2) cognitive abilities; reasoning and perception; the ability to articulate thoughts, memory function or impairment, etc; (3) communication and hearing; ability to communicate needs and understand instructions, etc; (4) vision; (5) physical functioning and skeletal problems; (6) incontinence of bowel/bladder; (7) psychosocial well-being; (8) mood and behavior; (9) activity interests; (10) diagnoses; (11) health conditions; (12) nutritional status; (13) oral or dental status; (14) skin conditions; (15) medication use and level of assistance needed with medications; (16) special treatments and procedures or special	A 025	A 025 As of the submission of this plan of correction the Resident evaluation has been updated to include physical functioning, skeletal problems, activity interests and skin conditions. All resident evaluations are in the process of being updated to reflect the changes. Updated evaluations are scheduled for completion on 06/30/2024. The facility has implemented the use of the electronic calendar feature in our web-based software program to track and schedule resident evaluation due dates. This function will allow emails and notifications to be sent to the Administrator, Resident Care Coordinator regarding ISP/ Evaluation due dates. Evaluations and ISP's will be scheduled for completion simultaneously.	in process 06/30/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	7204	A. BUILDING: _____ B. WING _____	05/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOW MANOR	815 W ADOBE DRIVE DEMING, NM 88030

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 025	Continued From page 6 medical needs such as hospice; and (17) safety needs/high risk behaviors; history of falls agitation, wandering, fire safety issues, etc. D. The resident evaluation shall include a history and physical examination and an evaluation report by a physician or a physician extender within six (6) months of admission. A resident shall have a medical evaluation by a physician or a physician extender at least annually. E. The resident evaluation shall be reviewed and if needed revised by a licensed practical nurse, registered nurse or physician extender at the time the individual service plan is reviewed, at a minimum of every six (6) months or when a significant change in health status occurs. [7.8.2.25 NMAC - Rp, 7.8.2.25 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.25 C (5) (9) (14) E Based on record review and interview, the facility failed to ensure for 4 (R #s 1-4) of 4 (R #s 1-4) residents whose evaluations were reviewed for compliance that their evaluations: 1. Included all the following abilities, behaviors or status: a. Information about physical functioning and skeletal problems. b. Information about the resident's activity interests. c. Information about skin conditions. 2. Resident evaluations were updated at a minimum of every six months at the time the Individual Service Plan (ISP) is reviewed.	A 025		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	7204	A. BUILDING: _____ B. WING _____	05/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOW MANOR	815 W ADOBE DRIVE DEMING, NM 88030

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 025	Continued From page 7 These deficient practices could likely result in the residents to be at risk of not getting the care and services needed if the Direct Care Staff (DCS) does not know what the residents' correct needs are. The findings are: R #1 A. Record review of R #1's resident evaluation dated 03/15[redacted] revealed: 1. It did not include information about physical functioning and skeletal problems. 2. It did not include information about the resident's activity interests. 3. It did not include information about skin conditions. B. Record review of R #1's resident file revealed the record did not contain an updated resident evaluation that was completed at the time the ISP was reviewed on 02/06/24. R #2 C. Record review of R #2's resident evaluation dated 03/21[redacted] revealed: 1. It did not include information about physical functioning and skeletal problems. 2. It did not include information about the resident's activity interests. 3. It did not include information about skin conditions. R #3 D. Record review of R #3's resident evaluation dated 07/24[redacted] revealed: 1. It did not include information about physical functioning and skeletal problems.	A 025		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	7204	A. BUILDING: _____ B. WING _____	05/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOW MANOR	815 W ADOBE DRIVE DEMING, NM 88030

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 025	Continued From page 8 2. It did not include information about the resident's activity interests. 3. It did not include information about skin conditions. E. Record review of R #3's resident evaluation dated 02/03[redacted] revealed: 1. It did not include information about physical functioning and skeletal problems. 2. It did not include information about the resident's activity interests. 3. It did not include information about skin conditions. R #4 F. Record review of R #4's resident evaluations dated 02/03/[redacted] revealed: 1. It did not include information about physical functioning and skeletal problems. 2. It did not include information about the resident's activity interests. 3. It did not include information about skin conditions. G. On 05/15/24 at 3:15 pm, during an interview, the Administrator confirmed the resident's evaluations for R #1-4 did not include: 1. Information about physical functioning and skeletal problems. 2. Information about the resident's activity interests. 3. Information about skin conditions.	A 025		
A 026	7 NMAC 8.2.26 Individual Service Plan INDIVIDUAL SERVICE PLAN (ISP): An ISP shall be developed and implemented within ten (10)	A 026		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	7204	A. BUILDING: _____ B. WING _____	05/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOW MANOR	815 W ADOBE DRIVE DEMING, NM 88030

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 026	Continued From page 9 calendar days of admission for each resident residing in the facility. A. The ISP shall address those areas of need as identified in the resident evaluation and through staff observation. (1) The ISP shall detail the services that are provided by the facility as well as the services to be provided by other agencies. (2) The resident evaluation and the ISP shall be reviewed and if needed revised by a licensed practical nurse, registered nurse or a physician extender. (3) The ISP shall be reviewed and or revised at a minimum of every six (6) months or when there is a significant change in the resident ' s health status. B. The ISP shall include the following: (1) a description of identified needs as noted in the resident evaluation; (2) a written description of all services to be provided; (3) who will provide the services; (4) when or how often the services will be provided; (5) how the services will be provided; (6) where the services will be provided; (7) expected goals and outcomes of the services; (8) documentation of the facility ' s determination that it is able to meet the needs of the resident; (9) the level of assistance that the resident will require with activities of daily living and with medications; (10) a crisis prevention/intervention plan when indicated by diagnosis or behavior; and (11) current orders for all medications, including those authorized for PRN usage. [7.8.2.26 NMAC - Rp, 7.8.2.26 NMAC, 01/15/2010]	A 026	A 026 As of the submission of this plan of correction the Resident Individual Service Plan template has been updated to identify the areas of need, identified in the Resident evaluation, which staff will provide services, when/how often the services will be provided, where the services will be provided, and the documentation of the facilities determination of ability to meet the needs of the Resident. All resident ISP's are in the process of being updated to reflect the changes. Updated ISP's are scheduled for completion on 06/30/2024. The facility has implemented the use of the electronic calendar feature in our web-based software program to track and schedule resident evaluation due dates. This function will allow emails and notifications to be sent to the Administrator, Resident Care Coordinator regarding ISP/Evaluation due dates. Evaluations and ISP's will be scheduled for completion simultaneously.	in process 06/30/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	7204	A. BUILDING: _____ B. WING _____	05/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOW MANOR	815 W ADOBE DRIVE DEMING, NM 88030

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 026	Continued From page 10 This REQUIREMENT is not met as evidenced by: 7.8.2.26 A (1) B (1) (3) (4) (6) (8) Based on record review, observation, and interview, the facility failed to ensure 4 (R #s 1-4) of 4(R #s 1-4) whose Individual Service Plans (ISP's) were reviewed for compliance that: 1. The ISP addressed the areas of need as identified in the resident evaluation. 2. The ISP stated which staff would provide the services. 3. The ISP stated when or how often the services will be provided. 4. The ISP stated where the services will be provided. 5. The ISP included documentation of the facility's determination that it is able to meet the needs of the resident. These deficient practices could likely result in harm to the residents not receiving appropriate care and services if the Direct Care Staff (DCS) are unaware of what care and services the resident needs. The findings are: R #1 A. On 05/13/24 at 3:01 pm, during an observation of R #1 at the table in the dining room, [redacted] was observed sitting in [redacted] wheelchair and used the wheelchair to get around the facility. B. Record review of R #1's ISP dated 02/06[redacted] revealed [redacted] was ambulatory and it did not include the use of a wheelchair as noted in the resident evaluation dated 03/15/[redacted] and 09/29/[redacted] (there	A 026		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	7204	A. BUILDING: _____ B. WING _____	05/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOW MANOR	815 W ADOBE DRIVE DEMING, NM 88030

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 026	Continued From page 11 was no evaluation provided for 02/06/[redacted] R #2 C. Record review of R #2's ISP dated 03/21[redacted] revealed the following: 1. The Special Care section stated, "[redacted]" but the ISP did not state which staff, where the services will be provided, and when or how often they the will be provided. 2. The ISP did not list any assistive devices, however, in the Resident Evaluation dated 03/21/[redacted] a wheelchair and walker were listed as needed device. 3. The ISP did needed documentation of the facility's determination that the facility was able to meet the needs of the resident. D. On 05/15/24 at 1:40 pm, during an interview, R #2 stated [redacted] uses a wheelchair and walker as an assistive device. R #3 E. Record review of R #3's ISP dated 07/24/[redacted] revealed it had not been updated every 6 months (due January 2024). F. Record review of R #3's ISP dated 07/24/[redacted] revealed the ISP did not include: 1. Documentation of the facilities determination that is it able to meet the needs of the resident. 2. The Special Care section stated, "[redacted]" and did not state which staff, where the services will be provided, and when or how often the services will be provided. 3. The safety section stated,'[redacted]" did not state which	A 026		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	7204	A. BUILDING: _____ B. WING _____	05/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOW MANOR	815 W ADOBE DRIVE DEMING, NM 88030

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 026	Continued From page 12 staff, where the services will be provided, and when or how often the services will be provided. G. Record review of R #3's ISP dated 02/03/[redacted] revealed the ISP did not include: 1. The Special Care section stated, [redacted]" and did not state which staff, where the services will be provided, and when or how often the services will be provided. 2. The Special Care section stated, [redacted]" and did not state which staff, where the services will be provided, and when or how often the services will be provided. 3. The safety section stated [redacted]" did not state which staff, where the services will be provided, and when or how often the services will be provided. R #4 H. Record review of R #4's ISP dated 07/24/[redacted] revealed the ISP did not include: 1. The need to monitor and document meal intake percentage as identified on the Resident Evaluation dated 07/24[redacted] 2. The use of an [redacted]) as identified on the Resident Evaluation dated 07/24[redacted]. I. Record review of R #4's ISP dated 02/03/[redacted] revealed it had not been updated every 6 months (due January 2024). J. On 05/15/24 at 3:15 pm, during an interview, the Administrator confirmed: 1. The ISPs for R #1 and 2 did not address the areas of need as identified in the resident evaluation. 2. The ISPs for R #s 1-4 did not include: a. Which staff would provide the services.	A 026		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	7204	A. BUILDING: _____ B. WING _____	05/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOW MANOR	815 W ADOBE DRIVE DEMING, NM 88030

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 026	Continued From page 13 b. When or how often the services will be provided. c. Where the services will be provided. d. Documentation of the facility's determination that it is able to meet the needs of the resident. 3. The ISP for R #4 dated 02/03[redacted] had not been updated every 6 months.	A 026		
A 027	7 NMAC 8.2.27 Resident Activities RESIDENT ACTIVITIES: Each facility shall provide or make available recreational and social activities appropriate to the residents ' abilities that meet their psychosocial needs and are relevant to their social history; including a balance of cognitive, reminiscence, physical and social activities. The facility shall post the activities and encourage residents to participate. [7.8.2.27 NMAC - Rp, 7.8.2.28 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.27 Based on observation, record review, and interview, the facility failed to provide activities that meet the needs of the residents. This deficient practice could likely affect the psychosocial well-being of all[redacted] (R #s[redacted]) residents identified on the census provided by the Administrator on 05/13/24, if activities are not available. The findings are: A. Record review of the posted Weekly Activity	A 027	A 027 As of the submission of this plan of correction an in-service for all staff was conducted on 06/13/2024 informing Direct Care Staff if an activity staff or volunteer is unable to provide scheduled activities the duty will transfer to office and/or care staff to ensure the activity is taking place as scheduled. A record of activity attendance has been created to be completed for each activity. This form will be turned into the Administrator monthly for review of completeness.	06/13/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	7204	A. BUILDING: _____ B. WING _____	05/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOW MANOR	815 W ADOBE DRIVE DEMING, NM 88030

(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 027	Continued From page 14 Calendar revealed the following scheduled activities: 1. Monday at 2:30 pm-Board games 2. Tuesday at 10:00 am- Fitness fun, 2:00 pm- Bingo. 3. Wednesday at 10:30 am- Crafts, and at 2:30 pm- Card games. B. On 05/13/24 at 3:41 pm, during an interview, R #3 stated [redacted] worked on puzzles independently because the facility does not have activities anymore (couldn't remember when last activity was offered). C. On 05/14/24 (Tuesday) at 2:09 pm, during an observation of the facility, no activities were occurring despite the posted schedule. D. On 05/15/24 at 3:10 pm, during an interview, the Administrator confirmed that there was no resident activities occurring at the facility because the volunteers recently quit.	A 027		
A 034	7 NMAC 8.2.34 Custodial Drug Permits CUSTODIAL DRUG PERMITS: A facility with two (2) or more residents that is licensed pursuant to this rule and that assists with self-administration or safeguards medications for residents shall have a current custodial drug permit issued by the state board of pharmacy. A. Procurement, labeling and storage. The facility shall provide assistance to the resident in obtaining the necessary medications, treatment and medical supplies as identified in the ISP. The facility shall procure, label and store medications for residents who require assistance with self-administration of medication in compliance with state and federal laws.	A 034	A 034 As of the submission of this plan of correction all combustible items and material have been removed from the oxygen storage room. Signage is placed on the door stating “Employees only oxygen storage, no flammable liquids or combustible materials allowed in this area. A facility walkthrough inspection has been added to the Administrator agenda for inspection of the oxygen storage room at least once a month to ensure no combustible materials are stored in the area. This walkthrough is scheduled on the Administrator’s agenda(calendar).	05/20/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	7204	A. BUILDING: _____ B. WING _____	05/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOW MANOR	815 W ADOBE DRIVE DEMING, NM 88030

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	7204	A. BUILDING: _____ B. WING _____	05/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOW MANOR	815 W ADOBE DRIVE DEMING, NM 88030

(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 16 (d) the prescriber ' s name; (e) the dose; (f) the signature of the person assisting with delivery of the medication; and (g) the balance of medication remaining. (9) Any remaining medication discontinued by a physician ' s order, or upon discharge or death of the resident shall be inventoried and moved to a separate locked storage container. Such discontinued medications shall be destroyed upon the next quarterly visit by the consulting pharmacist in accordance with 16.19.11.10 NMAC. (10) The record of medication destruction shall be signed by the administrator or designee and the pharmacist and shall be kept on file at the facility. B. Consulting pharmacist. The facility shall maintain records demonstrating that the consulting pharmacist provides the following oversight and guidance. (1) Reviews the medication regimen as needed, but at least quarterly/every three (3) months, to determine that all medications and records are accurate and current. All irregularities shall be reported to the administrator of the facility and these irregularities shall be resolved by the administrator within seventy-two (72) hours. (2) A system of records of receipt and disposition of all drugs in sufficient detail to enable an accurate reconciliation. (3) Consultation shall be provided on all aspects of pharmacy services in the facility, including reference information regarding side effects and, when needed, physician consultation in cases involving the use of psychotropic medications. (4) The consulting pharmacist will be responsible for assuring that the facility meets all requirements for storage, labeling, destruction	A 034		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	7204	A. BUILDING: _____ B. WING _____	05/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOW MANOR	815 W ADOBE DRIVE DEMING, NM 88030

(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 17 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 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	A 034		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	7204	A. BUILDING: _____ B. WING _____	05/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOW MANOR	815 W ADOBE DRIVE DEMING, NM 88030

(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 18 (3) Enclosed cabinet of noncombustible construction having a minimum fire protection rating of 1/2 hour 11.3.2.4 Gas cylinder and cryogenic liquid container storage shall comply with 5.1.3.5.12. 11.3.2.5 Cylinder and container storage locations shall comply with 5.1.3.3.1.7 with respect to temperature limitations. 11.3.2.6 Cylinder or container restraints shall comply with 11.6.2.3. 11.3.2.7 Smoking, open flames, electric heating elements, and other sources of ignition shall be prohibited within storage locations and within 6.1 m (20 ft) of outside storage locations. 11.3.2.8 Cylinder valve protection caps shall comply with 11.6.2.3. 11.3.2.9 Gas cylinder and liquefied gas container storage shall comply with 5.1.3.5.12. 11.3.3 Storage for nonflammable gases with a total volume equal to or less than 8.5 m3 (300 ft3) shall comply with the requirements in 11.3.3.1 and 11.3.3.2. 11.3.3.1 Individual cylinder storage associated with patient care areas, not to exceed 2100 m2 (22,500 ft2) of floor area, shall not be required to be stored in enclosures. 11.3.3.2 Precautions in handling cylinders specified in 11.3.3.1 shall be in accordance with 11.6.2. 11.3.3.3 When small-size (A, B, D, or E) cylinders are in use, they shall be attached to a cylinder stand or to medical equipment designed to receive and hold compressed gas cylinders. 11.3.3.4 Individual small-size (A, B, D, or E) cylinders available for immediate use in patient care areas shall not be considered to be in storage. 11.3.3.5 Cylinders shall not be chained to portable or movable apparatus such as beds and oxygen tents.	A 034		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	7204	A. BUILDING: _____ B. WING _____	05/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOW MANOR	815 W ADOBE DRIVE DEMING, NM 88030

(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 19 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 oxygen cylinder tanks were not stored with combustible materials (paper products, cardboard, and other materials that catch on fire and burn quickly or easily). This deficient practice could likely result in the [redacted] (R #s [redacted] residents listed on the resident census provided by the Administrator on 05/13/24, of being at risk of harm, injury, or death, if oxygen storage tanks were stored with combustible materials which could accelerate a fire. The findings are: A. On 05/13/24 at 2:51 pm, during observation of the oxygen storage room, the following combustible materials were stored with oxygen tanks: 1. Adult diapers. 2. Toilet paper rolls. 3. Rolls of gauze. 4. Boxes of tissue paper. B. On 05/13/24 at 2:51 pm, during an interview,	A 034		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	7204	A. BUILDING: _____ B. WING _____	05/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOW MANOR	815 W ADOBE DRIVE DEMING, NM 88030

(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 20 the Administrator confirmed that combustible materials were stored in the oxygen storage room with oxygen tanks.	A 034		
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 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	A 035	A 035 As of the submission of this plan of correction all Resident medication assistance records have been updated to include PCP/prescriber name, diagnosis or reason for medication, name of the medication including brand/ generic name, controlled substance notation for schedule II-IV medications, and antibiotic notation for antibiotic medication. On 06/13/2024 the Administrator conducted an in-service for all staff regarding requirement for medication assistance record completeness including: PCP/prescriber name, diagnosis or reason for medication, name of the medication including brand/ generic name, controlled substance notation for schedule II-IV medications, and antibiotic notation for antibiotic medication. The Administrator will review Resident medication assistance records monthly for completeness. A MAR review has been added to the Administrator agenda for review at least once a month.	06/13/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	7204	A. BUILDING: _____ B. WING _____	05/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOW MANOR	815 W ADOBE DRIVE DEMING, NM 88030

(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 035	Continued From page 21 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 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	A 035		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	7204	A. BUILDING: _____ B. WING _____	05/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOW MANOR	815 W ADOBE DRIVE DEMING, NM 88030

(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 035	Continued From page 22 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 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.	A 035		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	7204	A. BUILDING: _____ B. WING _____	05/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOW MANOR	815 W ADOBE DRIVE DEMING, NM 88030

(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 035	Continued From page 23 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] This REQUIREMENT is not met as evidenced by: 7.8.2.35 G (3) (4) (5) (6) Based on record review and interview, the facility failed to ensure for 4 (R #s 1-4) of 4 (R #s 1-4) residents that the medications listed on the Medication Administration Record (MAR) included: 1. The name of the resident's Primary Care Physician (PCP) or the prescriber of the medication.	A 035		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	7204	A. BUILDING: _____ B. WING _____	05/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOW MANOR	815 W ADOBE DRIVE DEMING, NM 88030

(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 035	Continued From page 24 2. The diagnosis or reason for the medication. 3. The name of the medication, including the drug product brand name and the generic name. 4. The notation if the medication is a schedule II-IV drug (controlled medications with both a low and high potential for abuse). These deficient practices could likely result in the residents being at risk of harm/injury from medication errors if the medications listed on the MARs do not include: 1. The name of the resident's PCP or the prescriber of the medication. 2. The diagnosis or reason for the medication and the Direct Care Staff (DCS) who assist with medications do not know what the medication is for. 3. The name of the medication, including the drug product brand name and the generic name. 4. The notation if the medication is a schedule II-IV drug. The findings are: R #1 A. Record review of R #1's partial MAR for May 2024 dated 05/01/24 through 05/13/24, revealed the following medications did not include the prescriber of the medication: 1. [redacted] 2 [redacted] 3 [redacted] 4. [redacted]	A 035		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	7204	A. BUILDING: _____ B. WING _____	05/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOW MANOR	815 W ADOBE DRIVE DEMING, NM 88030

(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 035	Continued From page 25	A 035		

[redacted]
5
[redacted]
6
[redacted]
7
[redacted]).
8.
[redacted]

B. Record review of R #1's partial MAR for May 2024, dated 05/01/24 through 05/13/24, revealed the following medications did not list the diagnosis or reason for the medication:

1. [redacted]
2. [redacted]

C. Record review of R #1's partial MAR for May 2024, dated 05/01/24 through 05/13/24, revealed the following medications did not include both the brand and generic names of the medications:

1. [redacted]

D. Record review of R #1's partial MAR for May 2024, dated 05/01/24 through 05/13/24, revealed the following medications did not include a notation if the medication is a schedule II-IV drug:

1. [redacted]

R #2

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	7204	A. BUILDING: _____ B. WING _____	05/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOW MANOR	815 W ADOBE DRIVE DEMING, NM 88030

(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 035	Continued From page 26 E. Record review of R #2's partial MAR for May 2024, dated 05/01/24 through 05/13/24, revealed the following medications did not include the name of the prescriber of the medication: 1. [redacted] 2. [redacted] 3. [redacted] 4. [redacted] 5. [redacted] 6. [redacted] 7. [redacted] 8. [redacted] 9. [redacted] 10. [redacted] 11. [redacted] 12. [redacted] 13. [redacted] 14. [redacted]	A 035		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	7204	A. BUILDING: _____ B. WING _____	05/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOW MANOR	815 W ADOBE DRIVE DEMING, NM 88030

(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 035	Continued From page 27 15. [redacted] F. Record review of R #2's partial MAR for May 2024, dated 05/01/24 through 05/13/24, revealed the following medications did not include a notation if the medication is a schedule II-IV drug: 1. [redacted] R #3 G. Record review of R #3's partial MAR for May 2024, dated 05/01/24 through 05/13/24, revealed the following medications did not list the diagnosis or reason for the medications: 1. [redacted] 2. [redacted] 3 [redacted] 4. [redacted] 5. [redacted] 6. [redacted] 7. [redacted] 8. [redacted] 9. [redacted]	A 035		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	7204	A. BUILDING: _____ B. WING _____	05/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOW MANOR	815 W ADOBE DRIVE DEMING, NM 88030

(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 035	Continued From page 28 H. Record review of R #3's partial MAR for May 2024, dated 05/01/24 through 05/13/24, revealed the following medications did not include the prescriber of the medication: 1. [redacted] 2. [redacted] 3. [redacted] 4. [redacted] 5 [redacted] 6. [redacted] 7. [redacted] 8. [redacted] 9. [redacted] 10. [redacted] 11. [redacted] 12. [redacted] 13. [redacted] 14. [redacted] 15. [redacted]	A 035		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	7204	A. BUILDING: _____ B. WING _____	05/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOW MANOR	815 W ADOBE DRIVE DEMING, NM 88030

(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 035	Continued From page 29 [redacted] 16. [redacted] I. Record review of R #3's partial MAR for May 2024, dated 05/01/24 through 05/13/24, revealed the following medications did not include a notation if the medication is a schedule II-IV drug: 1. [redacted] R #4 J. Record review of R #4's partial MAR for May 2024, dated 05/01/24 through 05/13/24, revealed the following medications did not list the diagnosis or reason for the medication: 1. [redacted] 2. [redacted] K. Record review of R #4's partial MAR for May 2024, dated 05/01/24 through 05/13/24, revealed the following medications did not include a notation if the medication is a schedule II-IV drug 1. [redacted] L. On 05/15/24 at 3:40 pm, during an interview, the Administrator confirmed the MAR did not list the following information: 1. The prescriber of the medication. 2. The diagnosis or reason for the medication. 3. The notation if the medication is a	A 035		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	7204	A. BUILDING: _____ B. WING _____	05/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOW MANOR	815 W ADOBE DRIVE DEMING, NM 88030

(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 035	Continued From page 30 schedule II-IV drug.	A 035	A 036 As of the submission of this plan of correction an in-service refresher was conducted by the Administrator for kitchen staff on 06/13/2024 regarding instruction in proper food storage, preparation and serving food, safety in food handling, appropriate personal hygiene, infectious and communicable disease control, dietary records, daily logs of the recorded temperatures for all facility refrigerators, freezers and steam tables, clean and sanitary conditions, dating/labeling food items and proper food serving temperatures. Additional staff have been scheduled through June 30, 2024 to aid in a thorough domestic cleaning of the facility kitchen. A kitchen cleanliness schedule has been created to aid kitchen staff with cleanliness routines. This form will be turned in monthly to the Administrator with other kitchen logs for completeness review. All food items have been moved to shelving at least six inches from the floor. A facility walkthrough inspection has been added to the Administrator agenda for inspection of the kitchen at least once a month to ensure clean sanitary conditions as well as a review of kitchen logs to ensure completeness, and random food temperature checks to ensure temperature correctness. This walkthrough/review is scheduled on the Administrator's agenda(calendar).	in process 06/30/2024
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 " 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	A 036		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	7204	A. BUILDING: _____ B. WING _____	05/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOW MANOR	815 W ADOBE DRIVE DEMING, NM 88030

(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 036	Continued From page 31 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; (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.	A 036		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	7204	A. BUILDING: _____ B. WING _____	05/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOW MANOR	815 W ADOBE DRIVE DEMING, NM 88030

(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 036	Continued From page 32 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 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	A 036		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	7204	A. BUILDING: _____ B. WING _____	05/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOW MANOR	815 W ADOBE DRIVE DEMING, NM 88030

(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 036	Continued From page 33 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 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	A 036		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	7204	A. BUILDING: _____ B. WING _____	05/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOW MANOR	815 W ADOBE DRIVE DEMING, NM 88030

(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 036	Continued From page 34	A 036		

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 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	7204	A. BUILDING: _____ B. WING _____	05/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOW MANOR	815 W ADOBE DRIVE DEMING, NM 88030

(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 036	Continued From page 35 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 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 B (4), C (1) (c), D (3) (7) (8) (b) Based on record review, observation, and interview, the facility failed to ensure: 1. There was a daily log of the recorded temperatures for all facility refrigerators and freezers maintained and available for inspection for thirty (30) calendar days. 2. The kitchen was maintained in a clean and sanitary condition. 3. The walls and floors were kept clean and in good repair. 4. Refrigerators and freezers were kept clean and sanitary at all times. 5. Food stored in refrigerators and freezers was dated, labeled, and were clean and sanitary. 6. Dry or staple food items shall be stored at least six (6) inches off the floor. 7. The hot food temperatures were maintained at a minimum of 140 degrees Fahrenheit (F) when served. 8. The dishwasher log shall be complete. These deficient practices could likely result in the	A 036		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	7204	A. BUILDING: _____ B. WING _____	05/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOW MANOR	815 W ADOBE DRIVE DEMING, NM 88030

(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 036	Continued From page 36 [redacted](R #s [redacted] residents listed on the census provided by the Administrator on 05/13/24, to be at risk of harm or contracting foodborne illnesses if: 1. There was not a daily log of the recorded temperatures for all facility refrigerators and freezers. 2. The kitchen, floors, walls, refrigerators, and freezers were not clean and in sanitary condition. 3. Food was not stored properly dated, labeled. 4. Dry or staple food items were not stored at least six (6) inches off the floor. 5. The hot food was not served at a minimum of 140 degrees F. The findings are: A. On 05/13/24 at 4:22 pm, during an observation of the kitchen, the following was revealed: 1. The walls, floors, and drain pipes were stained black and covered with a black layer of grease, dirt, liquid residue, and food particles. 2. The fridge and freezer were stained with food debris, residue, particles, and spills. B. On 05/13/24 at 4:28 pm, during an observation of the pantry in the kitchen, the following food was stored on a shelf that was two (2) inches off the ground: 1. Fifty-four (54) prune juice drinks. 2. Three, one-gallon jugs of vegetable oil. 3. One (1) box holding four one-gallon bottles of barbeque sauce. 4. One (1) large crate of multiple raw potatoes. C. On 05/13/24 at 4:17 pm, during an observation of the refrigerator in the kitchen, the	A 036		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	7204	A. BUILDING: _____ B. WING _____	05/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOW MANOR	815 W ADOBE DRIVE DEMING, NM 88030

(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 036	Continued From page 37 following was revealed 1. One (1)-gallon, opened and undated jug of barbecue sauce. 2. One (1) 138-ounce (oz), opened and undated container of salsa. 3. One (1)16-oz, opened and undated container of prunes. 4. One (1) gallon, opened, undated and unlabeled plastic bag bag of cheese. 5. One (1) gallon, opened and undated container of ranch dressing. 6. One (1) 16-oz, opened and undated container of parmesan cheese. 7. One (1) gallon, opened and undated container of pickles. 8. One (1) 15-oz, opened and undated container of butter. D. On 05/13/24 at 4:17 pm, during an observation of the freezer in the kitchen, the following was revealed: 1. One (1) half-gallon, opened and undated container of ice cream. 2. One (1) 40-oz, opened, undated and unlabeled bag of frozen vegetables. 3. One (1) gallon, opened, undated and unlabeled bag of breaded meat patty. 4. One (1) gallon, opened, undated and unlabeled bag of frozen carrots. E. On 05/13/24 at 5:00 pm, during an observation of the freezer in the laundry room, there was one (1) unknown large sized, opened, undated and unlabeled plastic bag of chicken legs. F. On 05/15/24 at 12:06 pm, during an observation of a lunch plate, the shredded barbeque chicken sandwich's internal temperature was measured at 120-degrees F	A 036		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	7204	A. BUILDING: _____ B. WING _____	05/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOW MANOR	815 W ADOBE DRIVE DEMING, NM 88030

(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 036	Continued From page 38 when the temperature was taken by the surveyor. G. On 05/15/24 at 12:07 pm, during an interview, the cook confirmed the temperature for the hot food was 120 degrees F. H. Record review of the partial May 2024 kitchen temperature log dated 05/01/24 through 05/13/24, revealed the following: 1. The refrigerator and freezer temperatures were not obtained or recorded. 2. Meal and food temperature logs were not obtained or recorded. 3. The dishwasher log was incomplete and not obtained the following days: a. 05/03/24 b. 05/04/24 c. 05/05/24 d. 05/07/24 through 05/13/24. I. On 05/15/24 at 3:45 pm, during an interview with the administrator, the Administrator confirmed: 1. The stained black walls, floors and drain pipes. 2. The food debris, residue, particles, and spills found in the fridge and freezer. 3. The items stored two (2) inches off the ground in the pantry. 4. The opened/undated/unlabeled food items in the fridge. 5. The opened/undated/unlabeled food items in the freezer. 6. The opened, undated and unlabeled plastic bag of chicken legs in the laundry room freezer. 7. The kitchen logs that were not obtained or recorded.	A 036		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	7204	A. BUILDING: _____ B. WING _____	05/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOW MANOR	815 W ADOBE DRIVE DEMING, NM 88030

(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 037	Continued From page 39 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. (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	A 037 A 037	A037 As of the submission of this plan of correction a locked door with signage reading “Employees only. Keep door closed at all times. On 06/13/2024 the Administrator conducted an in-service for all staff regarding laundry room security for Resident safety. A facility walkthrough inspection has been added to the Administrator agenda for inspection of the laundry facilities at least once a month to ensure security and safety for Residents. This walkthrough is scheduled on the Administrator’s agenda(calendar).	06/13/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	7204	A. BUILDING: _____ B. WING _____	05/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOW MANOR	815 W ADOBE DRIVE DEMING, NM 88030

(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 037	Continued From page 40 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, 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 laundry supplies were kept in a secured cabinet. This deficient practice has the potential for the [redacted] (R #s [redacted]) residents identified on the resident census provided by the Administrator on 05/13/24, to be at risk of harm or injury if they ingest, spill cleaning supplies/chemicals on their face or body. The findings are: A. On 05/14/24 at 10:50 am, during observation of the unlocked laundry room, there was one (1) 2.43-gallon container of laundry detergent stored on the dryer and accessible to residents. B. On 05/15/24 at 3:46 pm, during an interview with the Administrator, she confirmed the laundry cleaning supplies were not stored in a locked room or secured cabinet.	A 037		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	7204	A. BUILDING: _____ B. WING _____	05/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOW MANOR	815 W ADOBE DRIVE DEMING, NM 88030

(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 038	7 NMAC 8.2.38 Housekeeping Services HOUSEKEEPING SERVICES. The facility shall maintain the interior and exterior of the facility in a safe, clean, orderly and attractive manner. The facility shall be free from offensive odors, safety hazards, insects and rodents and accumulations of dirt, rubbish and dust. A. All common living areas and all bathrooms shall be cleaned as often as necessary to maintain a clean and sanitary environment. B. Combustibles such as cleaning rags or flammable substances shall be stored in closed metal containers in approved areas that provide adequate ventilation. Combustibles shall be stored away from the food preparation areas and away from the resident rooms. C. Poisonous or flammable substances shall not be stored in residential areas, food preparation areas or food storage areas. If hazardous chemicals are stored on the property, material safety data sheets shall be maintained and stored in the same area as the chemicals, pursuant to state environment department requirements, 11.5.2.9 NMAC. [7.8.2.38 NMAC - Rp, 7.8.2.39 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.38 A Based on observation and interview, the facility failed to ensure the facility was maintained in a clean and sanitary manner. This deficient practice could likely result in the [redacted] (R #s [redacted] residents listed on the census provided by the Administrator on 05/13/24, to be	A 038	A 038 As of the submission of this plan of correction an in-service was conducted by the Administrator for all staff on 06/13/2024 regarding clean and sanitary conditions, and providing timely housekeeping services including maintaining a clean, safe, sanitary, attractive environment. Additional staff have been scheduled through June 30, 2024 to aid in a thorough domestic cleaning of the entire facility. A facility walkthrough inspection has been added to the Administrator agenda for inspection of the facility at least once a month to ensure clean sanitary conditions. This walkthrough is scheduled on the Administrator's agenda(calendar).	06/13/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	7204	A. BUILDING: _____ B. WING _____	05/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOW MANOR	815 W ADOBE DRIVE DEMING, NM 88030

(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 038	Continued From page 42 at risk of harm, injury, or death if residents were exposed to bacteria, germs, dirt or waste. A. On 05/13/24 at 2:58 pm, during an observation of the dining room, revealed the following: 1. The upper cabinets contained food debris (particles/pieces/crumbs) and food stains. 2. The dining room drawers contained food debris and food stains. 3. The bottom dining room cabinets contained paper waste wrappers and food debris. 4. The walls in the dining room were stained, scuffed and splashed with food particles and dirty (grimy and unkept). B. On 05/13/24 at 5:20 pm, during an observation of the laundry room revealed the the following: 1. Had grimy, unkept (not tidy or cared for), and dusty. 2. Dirt particles on the floor. 3. Dark colored stains on the floor and walls. C. On 05/15/24 at 3:46 pm, during an interview, the Administrator confirmed the following: 1. The debris, food particles, and paper waste found in the dining room. 2. The grime, dirt, and stains found on the floor and walls.	A 038		
A 042	7 NMAC 8.2.42 Maintenance of Building and Grounds MAINTENANCE OF BUILDING AND GROUNDS: The building(s) shall be maintained in good repair at all times. Such maintenance shall include, but is not limited to, the following areas: A. Storage areas/grounds. Storage areas and	A 042	A 042 As of the submission of this plan of correction multiple 12-foot sized metal pipes are removed from the south facing patio area. A facility walkthrough inspection has been added to the Administrator agenda for inspection of the patios/outdoor common areas at least once a month to ensure security and safety for Residents. This walkthrough is scheduled on the Administrator's agenda(calendar).	05/22/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	7204	A. BUILDING: _____ B. WING _____	05/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOW MANOR	815 W ADOBE DRIVE DEMING, NM 88030

(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 042	Continued From page 43 grounds shall be maintained in a safe, sanitary and presentable condition at all times. Storage areas and grounds shall be kept free from accumulation of refuse, weeds, discarded furniture, old newspapers or other items that create a fire hazard. B. Floors. Floors shall be maintained stable, firm and free of tripping hazards. [7.8.2.42 NMAC - Rp, 7.8.2.43 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.42 A B Based on observation and interview, the facility failed to ensure the facility storage and the facility grounds/floors were maintained in a safe, sanitary, and presentable condition (clean, tidy, and generally pulled together). This deficient practice has the potential for all [redacted] (R #s [redacted] residents identified on the resident census provided by the Administrator 05/13/24, to be at risk of being injured from safety and tripping/falling hazards. The finding are: A. On 05/13/24 at 5:00 pm, during observation of the south facing patio, multiple 12 foot sized metal pipes were stored on the floor in the patio area. B. On 05/15/24 at 3:50 pm, during an interview, the Administrator confirmed the large metal pipes were being stored on the floor in the patio area.	A 042		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	7204	A. BUILDING: _____ B. WING _____	05/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOW MANOR	815 W ADOBE DRIVE DEMING, NM 88030

(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 047	Continued From page 44 7 NMAC 8.2.47 Lighting and Lighting Fixtures LIGHTING AND LIGHTING FIXTURES: A. All areas of the facility, including storerooms, stairways, hallways, and interior and exterior entrances shall be lighted to make the area clearly visible. B. Exits, exit-access ways and other areas used at night by residents and staff shall be illuminated by night lights or other continuous lighting. C. Lighting fixtures shall be selected and located to accommodate the needs and activities of the residents, with the comfort and convenience of the residents in mind. D. Lamps and lighting fixtures shall be shaded to prevent glare to the eyes of residents and staff, and protected from accidental breakage or shattering. E. Facilities with four (4) or more residents shall have emergency lighting to light exit passageways and the exterior area near the exits that activates automatically upon disruption of electrical service. F. Facilities with three (3) or fewer residents shall have a flashlight that is immediately available for use in lieu of electrically interconnected emergency lighting. [7.8.2.47 NMAC - Rp, 7.8.2.48 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.47 E Based on observation and interview, the facility failed to ensure that all emergency lights in the facility were in working order. This deficient practice could likely result in the	A 047 A 047	A 047 As of the submission of this plan of correction the emergency lights listed are repaired and functional. A facility walkthrough inspection has been added to the Administrator agenda for inspection of the emergency lights at least once a month to ensure proper functionality of emergency systems. This walkthrough is scheduled on the Administrator's agenda(calendar).	06/10/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	7204	A. BUILDING: _____ B. WING _____	05/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOW MANOR	815 W ADOBE DRIVE DEMING, NM 88030

(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 047	Continued From page 45 (R #s [redacted] residents identified on the resident census provided by the Administrator on 05/13/24, to be at risk of harm, injury, or death, if there is a power outage or other emergency requiring evacuation and the residents cannot see to safely exit the building. The findings are: A. On 05/14/24 at 11:40 am, during observation and testing of the emergency lights in the facility, the following lights failed to light up when tested: 1. The emergency light near [redacted] 2. The emergency light in the main dining room. B. On 05/14/24 at 3:43 pm, during an interview, the Administrator confirmed the emergency light near [redacted] and the emergency light in the main dining room failed to light up when tested.	A 047		
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	A 059	A 059 As of the submission of this plan of correction the window screens listed are repaired or replaced. On 06/14/2024 window screen repair/replacement is complete. A facility walkthrough inspection has been added to the Administrator agenda for inspection of the facility grounds at least once a month to ensure security and safety for Residents including inspection of window screens for missing/damages. This walkthrough is scheduled on the Administrator's agenda(calendar).	06/14/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	7204	A. BUILDING: _____ B. WING _____	05/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOW MANOR	815 W ADOBE DRIVE DEMING, NM 88030

(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 059	Continued From page 46 similar devices shall be reviewed and approved by the licensing authority prior to installation. D. Sleeping rooms, living rooms, activity room areas and dining room areas shall have a window area of at least one tenth (1/10) of the floor area with a minimum of ten (10) square feet. [7.8.2.59 NMAC - Rp, 7.8.2.52 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.59 B Based on observation and interview, the facility failed to ensure that all operable windows had screens and the screens were in good repair. This deficient practice could likely result in the [redacted] (R #s [redacted]) residents identified on the census provided by the Administrator on 05/13/24, to be at risk of illness and/or injury if the residents are subjected to insects, rodents, dust or debris entering through the bent frames, torn or missing window screens. The findings are: A. On 05/14/24 at 9:40 am, during observation of the exterior of the facility, revealed the following: 1. Three (3) window screens on the South side (front of facility) of the facility had bent screens. 2. Two (2) window screens on the east facing patio of the facility had bent screens. 3. One (1) window in [redacted] did not have a screen. 4. One (1) window in [redacted] had a bent screen. 5. One (1) window in [redacted] did not have a screen. 6. One (1) window in [redacted]	A 059		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	7204	A. BUILDING: _____ B. WING _____	05/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOW MANOR	815 W ADOBE DRIVE DEMING, NM 88030

(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 059	Continued From page 47 did not have a screen. 7. One (1) window in [redacted] did not have a screen. 8. One (1) window in [redacted] did not have a screen. 9. One (1) window in [redacted] did not have a screen. 10. One (1) window in [redacted] had a bent screen. 11. One (1) window in [redacted] had a bent screen. 12. One (1) window in [redacted] had a bent screen. 13. One (1) window in [redacted] had a bent screen. 14. One (1) window in [redacted] had a bent screen. 15. One (1) window in [redacted] did not have a screen. 16. One (1) window in [redacted] had a bent screen. 17. One (1) window in [redacted] did not have a screen. 18. One (1) window in [redacted] had a bent screen. 19. One (1) window in [redacted] had a bent screen. B. On 05/15/24 at 3:46 pm, during an interview, the Administrator confirmed that the window screens listed above were either torn, damaged, or missing, or had a bent frame.	A 059		
A 065	7 NMAC 8.2.65 Fire Drills FIRE DRILLS: All facilities shall conduct monthly fire drills which are to be documented. A. There shall be at least one (1) documented fire drill per month and at a minimum, one	A 065	A 065 As of the submission of this plan of correction the facility fire drill record has been updated to reflect total evacuation time, in minutes. On 06/13/2024 the Administrator conducted a full evacuation fire drill with total evacuation time recorded on the updated fire drill record. The updated form will be used for future monthly fire drills ensuring for total evacuation time. A facility life safety binder audit has been added to the Administrator agenda for monthly inspection of the facility life safety logs/drills to ensure completeness and compliance of fire drills. This audit is scheduled on the Administrator's agenda(calendar).	07/11/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	7204	A. BUILDING: _____ B. WING _____	05/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOW MANOR	815 W ADOBE DRIVE DEMING, NM 88030

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 065	Continued From page 48 documented fire drill each eight (8) hours (day, evening, night) per quarter that employs the use of the fire alarm system or the detector system in the facility. B. A record of the monthly fire drills shall be maintained on file in the facility and readily available. Fire drill records shall show: (1) the date of the drill; (2) the time of the drill; (3) the number of staff participating in the drill; (4) any problem noted during the drill; and (5) the evacuation time in total minutes. C. If applicable, the local fire department may be requested to supervise and participate in fire drills. [7.8.2.65 NMAC - Rp, 7.8.2.65 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.65 B (5) Based on record review and interview, the facility failed to ensure that the monthly fire drills document the evacuation time in total minutes. These deficient practices could likely result in the [redacted] (R #s [redacted] residents identified on the census, provided by the Administrator on 05/13/24, to be at risk of harm, injury, or death if a fire were to occur and the Direct Care Staff (DCS) do not know how to safely evacuate the residents from the building. The findings are: A. Record review of the facility's fire drill log dated 01/09/24 revealed the evacuation time in	A 065		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	7204	A. BUILDING: _____ B. WING _____	05/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOW MANOR	815 W ADOBE DRIVE DEMING, NM 88030

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 065	Continued From page 49 total minutes was not documented. B. Record review of the facility's fire drill log dated 02/23/24 revealed the evacuation time in total minutes was not documented. C. Record review of the facility's fire drill log dated 03/29/24 revealed the evacuation time in total minutes was not documented. D. Record review of the facility's fire drill log dated 04/30/24 revealed the evacuation time in total minutes was not documented. E. On 05/14/24 at 4:55 pm, during an interview, the Administrator confirmed that the evacuation time in total minutes documented in the fire drill logs dated 01/09/24, 02/23/24, 03/29/24, and 04/30/24 was not included.	A 065		
A 067	7 NMAC 8.2.67 Smoking SMOKING: A. Smoking by residents and staff shall take place only in supervised areas designated by the facility and approved by the state fire marshal or local fire prevention authorities. Smoking shall not be allowed in a kitchen or food preparation area. B. All designated smoking areas shall be provided with suitable ashtrays that are not made of combustible material. C. Residents shall not be permitted to smoke in bed. D. Smoking shall not be permitted where oxygen is in use, is present or is stored. [7.8.2.67 NMAC - Rp, 7.8.2.64 NMAC, 01/15/2010]	A 067	A 067 As of the submission of this plan of correction the Administrator released a memo and conducted an in-service for all staff regarding the facility smoking policy and allowable areas for smoking. A facility walkthrough inspection has been added to the Administrator agenda for inspection of the facility grounds at least once a month to ensure security and safety for Residents including following smoking policy. This walkthrough is scheduled on the Administrator's agenda(calendar). "No smoking" signage has been posted at the exterior south wall of the laundry area. The smoking policy will be reviewed annually by all staff with a signed acknowledgement of review placed in the employee file. Employee files will be audited by the Administrator for smoking policy acknowledgment at orientation and annually.	07/11/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	7204	A. BUILDING: _____ B. WING _____	05/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOW MANOR	815 W ADOBE DRIVE DEMING, NM 88030

(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 067	Continued From page 50 This REQUIREMENT is not met as evidenced by: 7.8.2.67 A Based on observation and interview, the facility failed to ensure that smoking only took place in a designated smoking area. This deficient practice could likely result in the [redacted] (R #s [redacted] residents identified on the census provided by the Administrator on 05/13/24, to be at risk of harm, injury, or death if a fire were to occur because staff are not using noncombustible ash trays to dispose cigarette butts safely. The findings are: A. On 05/13/24 at 5:00 pm, during observation of the southside laundry room walk path, multiple cigarette butts were discarded on the ground alongside of the walk path. B. On 05/15/24 at 3:49 pm, during an interview, the Administrator confirmed smoking took place in a non-designated smoking area.	A 067		