

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROV DER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 2264	(X2) MULT PLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 08/29/2019
NAME OF PROVIDER OR SUPPLIER GENNEY'S SENIOR CARE LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 1504 37TH STREET SE RIO RANCHO, NM 87124		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 000	Initial Comments The following deficiencies were cited during a Full-Onsite/Complaint survey completed on 08/29/19 for the state requirements of 7 NMAC 8.2, Regulations for Assisted Living. Complaint #NM 35647 was unsubstantiated with no deficiencies cited.	A 000		
A 026	7 NMAC 8.2.26 Individual Service Plan INDIVIDUAL SERVICE PLAN (ISP): An ISP shall be developed and implemented within ten (10) calendar days of admission for each resident residing in the facility. A. The ISP shall address those areas of need as identified in the resident evaluation and through staff observation. (1) The ISP shall detail the services that are provided by the facility as well as the services to be provided by other agencies. (2) The resident evaluation and the ISP shall be reviewed and if needed revised by a licensed practical nurse, registered nurse or a physician extender. (3) The ISP shall be reviewed and or revised at a minimum of every six (6) months or when there is a significant change in the resident ' s health status. B. The ISP shall include the following: (1) a description of identified needs as noted in the resident evaluation; (2) a written description of all services to be provided; (3) who will provide the services; (4) when or how often the services will be provided; (5) how the services will be provided; (6) where the services will be provided; (7) expected goals and outcomes of the services;	A 026		

Division of Health Improvement
LABORATORY D RECTOR'S OR PROV DER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 2264	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 08/29/2019
NAME OF PROVIDER OR SUPPLIER GENNEY'S SENIOR CARE LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 1504 37TH STREET SE RIO RANCHO, NM 87124		
(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 1 (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] This REQUIREMENT is not met as evidenced by: 7.8.2.26 (B) (8-9, 11) Based on record review and interview, the facility failed to ensure that for 2 (R #s 2 and 4) of 3 (R #s 2-4) residents whose Individual Service Plans (ISP) were reviewed for compliance included: 1. Documentation that a description of identified needs as noted in the resident evaluation were considered in the development of the ISPs. 2. When or how often the services will be provided. 3. Documentation of the facility's ability to meet the needs of the resident. 4. Current orders for all medications, including those authorized for PRN (as needed) usage. These deficient practices have the potential for all residents to be at risk of harm, injury, illness and/or death if the: 1. Resident ISPs do not address the resident's needs as noted in the evaluation. 2. Direct Care Staff (DCS) are unaware of	A 026			

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROV DER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 2264	(X2) MULT PLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 08/29/2019
NAME OF PROVIDER OR SUPPLIER GENNEY'S SENIOR CARE LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 1504 37TH STREET SE RIO RANCHO, NM 87124		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCS (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG 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 2 individual care/services needed by the residents or when/how often the care/services will be provided. 3. Facility does not have capability to provide the care/services needed. 4. DCS do not know what medications the resident is taking or how the medication was ordered by the physician. The findings are: A. Record review of R #2's ISPs dated 03/11/19 & 08/25/19 revealed no documentation of: 1. When or how often the services will be provided; 2. Documentation of the facility's determination that it is able to meet the needs of the resident; 3. Current orders for all medications, including those authorized for PRN usage. B. Record review of R #4's resident ISPs dated 03/11/19 & 08/25/19 revealed no documentation of: 1. When or how often the services will be provided; 2. Documentation of the facility's determination that it is able to meet the needs of the resident; 3. Current orders for all medications, including those authorized for PRN usage. C. On 08/29/19 at 11:15 am, during an interview with the Administrator and Supervisor, they stated that all resident ISPs were prepared and developed by their Community Service Provider, then reviewed by the DCS. They both confirmed that R #s 2 & 4's ISPs did not include the missing information listed above.	A 026		

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROV DER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 2264	(X2) MULT PLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 08/29/2019
NAME OF PROVIDER OR SUPPLIER GENNEY'S SENIOR CARE LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 1504 37TH STREET SE RIO RANCHO, NM 87124		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG 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 3	A 035		
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 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	A 035		

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROV DER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 2264	(X2) MULT PLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 08/29/2019
NAME OF PROVIDER OR SUPPLIER GENNEY'S SENIOR CARE LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 1504 37TH STREET SE RIO RANCHO, NM 87124		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG 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 4 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 drug; (7) the dosage of the medication; (8) the strength of the medication; (9) the frequency or how often the medication is	A 035		

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROV DER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 2264	(X2) MULT PLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 08/29/2019
NAME OF PROVIDER OR SUPPLIER GENNEY'S SENIOR CARE LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 1504 37TH STREET SE RIO RANCHO, NM 87124		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG 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 5 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. 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:	A 035		

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 2264	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 08/29/2019
NAME OF PROVIDER OR SUPPLIER GENNEY'S SENIOR CARE LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 1504 37TH STREET SE RIO RANCHO, NM 87124		
(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 6 (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 (4-5) Based on record review and interview, the facility failed to ensure for 3 (R #s 2-4) of 3 (R #s 2-4) residents whose Medication Administration Records (MARs) were reviewed for compliance included the diagnosis/reason for and both the brand/generic names for the medications. This deficient practice has the potential for all residents to be at risk of harm, injury, or death if the medications listed on the MARs do not include both the diagnosis/reason for and/or the brand/generic names, and the Direct Care Staff (DCS) who assist with medications do not know	A 035			

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROV DER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 2264	(X2) MULT PLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 08/29/2019
NAME OF PROVIDER OR SUPPLIER GENNEY'S SENIOR CARE LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 1504 37TH STREET SE RIO RANCHO, NM 87124		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D 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 7 what health conditions the medication is treating and/or which medication (new name) is for. The findings are: Findings related to diagnosis/reason for medications. A. Record review of R #2's [REDACTED]/19 through [REDACTED]/19 MAR revealed no documentation of the the diagnosis/reason for the following medications: [REDACTED] B. Record review of R #3's [REDACTED]/19 through [REDACTED]/19 MAR revealed no documentation of the the diagnosis/reason for the following medications: [REDACTED] C. Record review of R #4's [REDACTED]/19 through [REDACTED]/19 MAR revealed no documentation of the the diagnosis/reason for the following medications: [REDACTED]	A 035		

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROV DER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 2264	(X2) MULT PLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 08/29/2019
NAME OF PROVIDER OR SUPPLIER GENNEY'S SENIOR CARE LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 1504 37TH STREET SE RIO RANCHO, NM 87124		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D 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 8 Findings related to Brand/Generic names of medications D. Record review of R #2's [REDACTED]/19 through [REDACTED]/19 MAR revealed no documentation of both the Brand/Generic names for the following medications: [REDACTED] E. Record review of R #3's [REDACTED]/19 through [REDACTED] 19 MAR revealed no documentation of both the Brand/Generic names for the following medications: [REDACTED] F. Record review of R #4's [REDACTED]/19 through [REDACTED]/19 MAR revealed no documentation of both	A 035		

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROV DER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 2264	(X2) MULT PLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 08/29/2019
NAME OF PROVIDER OR SUPPLIER GENNEY'S SENIOR CARE LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 1504 37TH STREET SE RIO RANCHO, NM 87124		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D 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 9 the Brand/Generic name for the following medications:  G. On 08/29/19 at 11:15 am, during an interview with the Administrator and Supervisor, they confirmed that the MARs for R #s 2-4 were missing the diagnosis/reason for and the brand/generic name for the above listed medications.	A 035		
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 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]	A 042		

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROV DER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 2264	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 08/29/2019
NAME OF PROVIDER OR SUPPLIER GENNEY'S SENIOR CARE LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 1504 37TH STREET SE RIO RANCHO, NM 87124		
(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 10 This REQUIREMENT is not met as evidenced by: 7.8.2.42 A Based on observation and interview, the facility failed to ensure that the grounds were maintained in a safe, sanitary, presentable condition, and kept free from accumulation of weeds, tree cuttings, debris, televisions, furniture, and boxed miscellaneous items. This deficient practice has the potential of all 5 (R #s 1-5) residents on the census provided by the Administrator on 08/27/19, to be at risk of exposure to disease, and at risk of harm, illness, or death if they were exposed to trash and refuse that present tripping, falling or fire hazards. The findings are: A. On 08/27/19 at 9:05 am, during an observation of the back yard the following was observed: 1. Boxes with deceased resident's belongings and bed. 2. Accumulation of weeds between the storage buildings. 3. Televisions and discarded oak entertainment center. 4. Tree cuttings including branches and cut logs. B. On 8/28/19 at 9:58 am, during an interview with Supervisor, he confirmed the presence of the weeds, tree cuttings, debris, televisions, furniture, and boxed miscellaneous items that needed to be cleared, stored securely, and discarded to prevent health/safety hazards.	A 042		

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 2264	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 08/29/2019
NAME OF PROVIDER OR SUPPLIER GENNEY'S SENIOR CARE LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 1504 37TH STREET SE RIO RANCHO, NM 87124		
(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 061	Continued From page 11	A 061			
A 061	7 NMAC 8.2.61 Fire Alarms, Smoke Detectors and Other Equip FIRE ALARMS, SMOKE DETECTORS AND OTHER EQUIPMENT: A. Fire alarm system. Facilities with four (4) or more residents shall have a manual fire alarm system. The manual fire alarm shall be inspected and approved in writing by the fire authority with jurisdiction. B. Smoke and heat detection. Approved smoke detectors shall be installed on each floor that when activated provides an alarm which is audible in all sleeping areas. Areas of assembly, such as the dining and living room(s) must also be provided with smoke detectors. (1) Detectors shall be powered by the house electrical service and have battery back up. (2) Construction of new facilities or facilities remodeling or replacing existing smoke detectors shall provide detectors in common living areas and in each sleeping room. (3) Smoke detectors shall be installed in corridors at no more than thirty (30) foot spacing. (4) Heat detectors shall be installed in all kitchens and also powered by the house electrical service. [7.8.2.61 NMAC - Rp, 7.8.2.60 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.61 B (4) Based on observation and interview, the facility failed to ensure that a heat detector was installed in the kitchen. This deficient practice has the potential for all 5 (R #s 1-5) residents on the census provided by the Administrator on	A 061			

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 2264	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 08/29/2019
NAME OF PROVIDER OR SUPPLIER GENNEY'S SENIOR CARE LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 1504 37TH STREET SE RIO RANCHO, NM 87124		
(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 061	Continued From page 12 08/27/19, staff, and all occupants to be at risk of harm or death if a fire goes undetected in the kitchen area & there is a delay in an alarm alerting the occupants of a fire. The findings are: A. On 8/27/19 at 11:30 am, during an observation of the kitchen, it was observed that no heat detector was installed. B. On 8/28/19 at 10:10 am, during an interview with the Supervisor, he confirmed there is no heat detector installed in the kitchen.	A 061		
A 063	7 NMAC 8.2.63 Fire Extinguishers FIRE EXTINGUISHERS: Fire extinguisher(s) must be located in the facility, as approved by the state fire marshal or the fire prevention authority with jurisdiction. A. Facilities must as a minimum have two (2) 2A10BC fire extinguishers: (1) one (1) extinguisher located in the kitchen or food preparation area; (2) one (1) extinguisher centrally located in the facility; (3) all fire extinguishers shall be inspected yearly and recharged as needed; all fire extinguishers must be tagged noting the date of the inspection; (4) the maximum distance between fire extinguishers shall be fifty (50) feet. B. Fire extinguishers, alarm systems, automatic detection equipment and other fire fighting equipment shall be properly maintained and inspected as recommended by the manufacturer, state fire marshal, or the local fire authority. [7.8.2.63 NMAC - Rp, 7.8.2.62 NMAC, 01/15/2010]	A 063		

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROV DER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 2264	(X2) MULT PLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 08/29/2019
NAME OF PROVIDER OR SUPPLIER GENNEY'S SENIOR CARE LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 1504 37TH STREET SE RIO RANCHO, NM 87124		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 063	Continued From page 13 This REQUIREMENT is not met as evidenced by: 7.8.2.63 B Based on observation, record review and interview, the facility failed to ensure that the 3 facility fire extinguishers were inspected monthly as recommended by the manufacturer. This deficient practice has the potential for all 5 (R #s 1-5) residents on the census provided by the Administrator on 08/27/19, staff, and all occupants of the building, to be at risk of injury or death if there is a fire and the fire extinguishers do not work properly. The findings are: A. On 08/27/19 at 9:25 am, an observation of the 3 facility fire extinguishers revealed no documentation that they had been inspected monthly as recommend by the manufacturer B. On 08/29/19 at 11:15 am, during an interview with the Administrator and Supervisor, they confirmed that the fire extinguishers were not being inspected monthly.	A 063		