NEW MEXICO
Department of Health
Division of Health Improvement

MICHELLE LUJAN GRISHAM
Governor

DAVID R. SCRASE, M.D.
Acting Cabinet Secretary

June 10, 2022

Carolyn Montoya-Herrera, Administrator
Life Spire Assisted Living of Rio Rancho
1001 24th St
Rio Rancho, NM 87124

License # 2216

IMPORTANT NOTICE - PLEASE READ IMMEDIATELY

Dear Ms. Montoya-Herrera:

On **June 2, 2022**, a Complaint Survey was conducted at Life Spire Assisted Living of Rio Rancho by the Department of Health (DOH) to determine if your facility was in compliance with the New Mexico State Requirements for Assisted Living Facilities. This survey found that your facility was not in compliance with the participation requirements.

Plan of Correction (PoC)
Your PoC for the deficiencies listed on the State Form **must be submitted within ten (10) calendar days** from your receipt of this form. Failure to submit an acceptable PoC may result in sanctions, including but not limited to civil monetary penalties, suspension, or non-renewal of the facility license [NMAC 7.8.2.12(B)(5)]. Include a completion date for each deficiency cited. Your PoC **shall**:

1. Address how all violations identified in the official statement of deficiencies will be corrected;

2. Address how the facility will monitor the corrective action and ensure ongoing compliance; and

3. Specify the date that the corrective action will be completed.

Please submit your PoC under the appropriate column on the enclosed State Form. Address each deficiency and include the month, date and year of the expected completion date. **Sign, date, and indicate your title in the appropriate blocks on page 1 of the form.** Return the State Form within ten (10) calendar days, with the PoCs to the DOH via fax, email or mail to the attention of:

Review Office
2040 S. Pacheco St. 2nd Floor Room 202
Santa Fe, NM 87505
Phone: (505) 476-9031/Fax: (505) 476-9048
HFLC.Review@state.nm.us

The State Form must be printed as it was sent to you and put your PoCs on the original State Form. You are not permitted to alter the State Form in any way.

Informal Dispute Review (IDR)
You have an opportunity to contest any cited deficiency through an Informal Dispute Review (IDR) process, 7.8.2.12 NMAC. If you choose to contest a cited deficiency, you must specify the exact deficiency being disputed along with an explanation of why you are disputing the deficiency **in writing**. All supporting evidence must be provided with the IDR request. **You will be required to submit one (1) copy of all supporting documents that have been properly redacted (with coded identifiers replacing actual resident and facility identifiers) and one (1) copy of all supporting documents unredacted, to the Review Office, 2040 S. Pacheco St. 2nd Floor Room 202, Santa Fe, NM 87505, (505) 476-9031,** by the tenth (10th) calendar day from receipt of this letter. Failure to meet this timeframe waives your right to the IDR process. You will be advised in writing of the results relative to the IDR. **You are still required to submit your PoC within the timeframe.**

An IDR request for any cited deficiency will not delay the imposition of the enforcement actions. If the deficiency is removed, a new statement of deficiencies will be issued to the facility.

If you have additional questions regarding this notice, please contact me at (505) 476 - 9039.

Sincerely,

Maurella Sooh
District Operations Bureau Chief
District Operations Bureau
Division of Health Improvement

Attachments: June 2, 2022, Health State Form

Please take a moment to complete an online survey regarding your experience with DHI. You can find this on Survey Monkey at the following link:

https://www.surveymonkey.com/r/DHI_Health_Facility_Customer_Satisfaction_Survey

Your responses are completely anonymous and will be used to improve our performance. We may periodically share the results of these surveys with relevant trade associations as well.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2216	A. BUILDING: _____ B. WING _____	C 06/02/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE SPIRE ASSISTED LIVING OF RIO RANCHO	1001 24TH ST 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 000	Initial Comments The following deficiencies were cited during an Full-Onsite/Complaint survey completed on 06/02/22 for the state requirements of 7 NMAC 8.2, Regulations for Assisted Living Facilities. Complaint Intake #50390 was unsubstantiated with no deficiencies cited. Complaint Intake #52767 was substantiated with deficiencies cited.	A 000		
A 016	7 NMAC 8.2.16 Staff Qualifications STAFF QUALIFICATIONS: A facility shall employ staff with the following qualifications. A. Administrator, director, operator: an assisted living facility shall be supervised by a full-time administrator. Multiple facilities that are located within a forty (40) mile radius may have one full-time administrator. The administrator shall: (1) be at least twenty-one (21) years of age; (2) have a high school diploma or its equivalent; (3) comply with the requirements of the New Mexico Caregivers Criminal History Screening Act, 7.1.9 NMAC; (4) complete a state approved certification program for assisted living administrators; (5) be able to communicate with the residents in the language spoken by the majority of the residents; (6) not work while under the influence of alcohol or illegal drugs; (7) have evidence of education and experience to prove the ability to administer, direct and operate an assisted living facility; the evidence of education and experience shall be directly related to the services that are provided at the facility; (8) provide three (3) notarized letters of reference from persons unrelated to the applicant; and (9) comply with the pre-employment requirements	A 016		

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

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A 016	Continued From page 2 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.16 B (7) 7.1.9.8 CAREGIVER AND HOSPITAL CAREGIVER EMPLOYMENT REQUIREMENTS: . . . D. Application: In order for a nationwide criminal history record to be obtained and processed, the following shall be submitted to the department on forms provided by the department. (1) A form containing personal identification which has a photograph of the person and which meets the requirements for employment eligibility in accordance with the immigration and nationality act as amended. A reasonable xerographic copy of a drivers license photograph will suffice under Subsection D of 7.1.9.8 NMAC. 2) A signed authorization for release of information form. (3) Three (3) complete sets of readable fingerprint cards or other department approved media acceptable to the Department of Public Safety and the Federal Bureau of Investigation submitted using black ink. (4) The fee specified by the department for the nationwide and statewide criminal history screening investigation shall not exceed seventy-four ($74) dollars. Of which, twenty-four ($24) dollars shall be applied for the federal bureau of investigation nationwide criminal history screening, seven ($7) dollars shall be applied for the statewide criminal history screening. The remaining application fee shall be applied to cover costs incurred by the Department to	A 016		

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A 016	Continued From page 3 support activities required by the Act and these rules. The fees will not be applied to any other activity or expense undertaken by the Department. . . . E. Fees: The federal bureau of investigation has a mandatory processing fee with no exceptions. The Department and Department of Public Safety impose a state processing and administrative fee. The fee payment must accompany the fingerprint application, or otherwise be credited to the department prior to or at the same time with the department's receipt of the application documents. The manner of payment of the fee is by bank cashier check or money order payable to the New Mexico Department of Health or other method of funds transfer acceptable to the department. Business checks will be accepted unless the business tendering the check has previously tendered a check to the department unsupported by sufficient funds. Neither cash nor personal checks will be accepted. The fee may be paid by the care provider or by the applicant, caregiver or hospital caregiver. The department will set a fee in addition to the fees imposed by Department of Public Safety and the Federal Bureau of Investigation that will fully and completely cover costs incurred by the department to support activities required by the act and these rules. The fees will not be applied to any other activity or expense undertaken by the department. F. Timely Submission: Care providers shall submit all fees and pertinent application information for all individuals who meet the definition of an applicant, caregiver or hospital caregiver as described in Subsections B, D and K of 7.1.9.7 NMAC, no later than twenty (20) calendar days from the first day of employment or	A 016		

vision of Health Improvement

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A 016	Continued From page 4 effective date of a contractual relationship with the care provider. G. Maintenance of Records: Care providers shall maintain documentation relating to all employees and contractors evidencing compliance with the act and these rules. (1) During the term of employment, care providers shall maintain evidence of each applicant, caregiver or hospital caregiver's clearance, pending reconsideration, or disqualification. (2) Care providers shall maintain documented evidence showing the basis for any determination by the care provider that an employee or contractor performs job functions that do not fall within the scope of the requirement for nationwide or statewide criminal history screening. A memorandum in an employee's file stating "This employee does not provide direct care or have routine unsupervised physical or financial access to care recipients served by [name of care provider]," together with the employee's job description, shall suffice for record keeping purposes. Based on record review and interview, the facility failed to ensure that the applications for fingerprints for the New Mexico Caregivers Criminal History Screening Program (CCHSP) were submitted within 20 days of hire. This deficient practice could likely negatively affect the safety and welfare of the 28 (R #s 1-28) residents listed on the census provided by the Administrator on 05/17/22, if they are being provided care and services by Direct Care Staff (DCS) who have a criminal background. The findings are: A. Record review of DCS #3's employee file (date of hire 03/30/22) revealed:	A 016	A016 NMAC 8.2.16 All direct care staff that fail to submit for fingerprints w/i 20 days shall be removed from floor on 20th day. Admin assistant will follow-up w CCHSP every 7 days from date of hire to ensure receipt & clearance in order to continue employment. and or instruct removal until completed. Admin Assistant & HR will review HR personal records & payroll to assure that non-compliant Employees are not on the floor to assure safety & wellness of residents. DCS #3 has completed fingerprints & now has clearance on file. Admin	6/3/22

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A 016	Continued From page 5 1. There was no clearance letter received from CCHSP. 2. The fingerprint authorization form was not signed by DCS #3 and there was no documentation that it had been submitted within 20-days of hire. B. On 05/23/22 at 12:30 pm, during an interview with the House Manager, she confirmed that DCS #3 had never gone to get fingerprinted. C. On 05/25/22 at 8:33 am, during an interview with the Administrative Assistant, she confirmed that DCS #3 had never gone to get fingerprinted and that she was no longer working on the floor.	A 016	A021 8.2.21 DCS Service notes shall be made available within 24 hrs + obtained from corporate office for all discharged residents Operations Manager will be responsible + able to obtain all resident records immediately. Operations Manager will train all staff + Managers on proper incident documentation of any behavior resulting in self neglect. Operation Manager will train Managers + DCS on ISP documentation to reflect issues. Operations Manager will complete a review of resident ISP to identify residents affected by Self Care.	6/30/22
A 021	7 NMAC 8.2.21 Resident Records RESIDENT RECORDS: A. Record contents. A record for each resident shall be maintained in accordance with the specific requirements of this section. Entries in each resident's record shall be legible, dated and authenticated by the signature of the person making the entry. Resident records shall be readily available on site and organized utilizing a table of contents. Each resident record shall include: (1) the admission agreement records, as set forth in 7.8.2.20 NMAC; (2) the resident evaluation form, that is to be completed within fifteen (15) days prior to admission and updated at a minimum of every six (6) months; (3) the current ISP, that is to be completed within ten (10) calendar days of admission and updated at a minimum of every six (6) months; (4) the physical examination report; the physical examination report shall have been completed	A 021		

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A 021	Continued From page 6 within the past six (6) months, by a primary care physician, a nurse practitioner or a physician ' s assistant and shall be on file in the resident ' s record within ten (10) days of admission; (5) personal and demographic information for the resident, to include: (a) current names, addresses, relationship and phone numbers of family members, or surrogate decision makers updated as necessary; (b) resident's name; (c) age; (d) recent photograph; (e) marital status; (f) date of birth; (g) sex; (h) address prior to admission; (i) religion (optional); (j) personal physician; (k) dentist; (l) social history; (m) surrogate decision maker or other emergency contact person; (n) language spoken and understood; (o) legal documentation relevant to commitment or guardianship status; (p) current medications list; and (q) required diet; (6) unless included in the admission agreement, a separate written agreement between the facility and the resident relating to the resident's funds, in accordance with the facility's policy and procedures; (7) entries by direct care staff, appropriate health care professionals and others authorized to care for the resident; entries shall be dated and signed by the person making the entry and shall include significant information related to the ISP; (8) entries that provide a written account of all accidents, injuries, illnesses, medical and dental	A 021		

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A 021	Continued From page 7 appointments, any problems or improvements observed in the resident, any condition that would indicate a need for alternative placement or medical attention and entries reflecting appropriate follow-up; the maintenance of such written documentation in the resident record may be by copy of an incident or accident report, if the original incident or accident report is maintained elsewhere by the facility; (9) the medication assistance record (MAR); the MAR is the document that details the resident's medication; the MAR shall include all of the information pursuant to Subsection G of 7.8.2.35 NMAC of this rule; (10) progress notes completed by any contract agency (e.g., hospice, home health); the progress notes shall include the date, time and type of health services provided; (11) copies of all completed and signed transfer forms from the accepting facility when a resident is transferred to a hospital or another health care facility and when the resident is transferred back to the facility; and (12) upon the death or transfer of a resident, documentation of the disposition of the resident's personal effects and money or valuables that are deposited with the assisted living facility. B. Resident records maintenance. (1) Current resident records shall be maintained on-site and stored in an organized, accessible and permanent manner. (2) The facility shall establish a policy to maintain and ensure the confidentiality of resident records, including the authorized release of information from the resident records. (3) Non-current resident records shall be maintained by the facility against loss, destruction and unauthorized use for a period of not less than five (5) years from the date of discharge and	A 021		

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A 021	Continued From page 8 readily available within twenty-four (24) hours of request. (4) There shall be a policy and procedure in place for record retention in the event of facility closure. (5) Failure to follow facility policies is grounds for sanctions. [7.8.2.21 NMAC - Rp, 7.8.2.22 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.21 A (7 & 8) B (3) Based on record review and interview, the facility failed to ensure for 1(R #5) of 6 (R #s 1-6) former and current residents whose resident records were reviewed for compliance, included Direct Care Staff (DCS) notes and the former resident's file was available within 24 hours of request. This deficient practice could likely result in the resident being at risk of neglect, if the: 1. DCS are not documenting the resident's behaviors and the amount/type of assistance with Activities of Daily Living (ADLs) being provided. 2. Facility is not maintaining the former resident records in a way, that they were available to the Licensing Authority within 24 hours. 3. DCS providing care and services to the resident are not aware of behaviors associated with self neglect. 4. There is no oversite by the Licensing Authority. The findings are: A. On 05/19/22 at 9:20 am, during an interview with the House Manager, she confirmed that DCS	A 021		

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A 021	Continued From page 9 should be completing progress notes on the residents care and associated behaviors of the resident that prevented the DCS from performing/providing the correct ADL assistance. B. Record review of R #5's resident file, revealed no documentation of the facility's DCS notes to indicate that R #5 had received ADL assistance and had behaviors associated with self-neglect. C. On 05/19/22 at 9:20 am, during an interview with the House Manager, she confirmed that R #5's resident files were not organized, lacked DCS progress notes to confirm the resident was receiving ADL assistance and had behaviors associated with self-neglect, and were not available for review by the Licensing Authority within 24 hours.	A 021		
A 032	7 NMAC 8.2.32 Reporting of Incidents REPORTING OF INCIDENTS: A. The facility shall insure that all suspected cases or known incidents of resident abuse, neglect or exploitation are reported in accordance with 7.1.13 NMAC. (1) The facility shall also report any incident or unusual occurrence which has or could threaten the health, safety, or welfare of the residents and staff to the licensing authority complaint hotline within twenty-four (24) hours or by the next business day, if it is a weekend or a holiday. (2) The facility shall not delay a report to the complaint hotline while an internal investigation is conducted. B. The facility is responsible for conducting and documenting the investigation of all incidents within five (5) business days and shall submit a copy of the investigation report to the licensing	A 032	A032 8.2.32 Mangers will retake a course on incident reporting + in turn will re-train staff on incidents requiring incident reports to be submitted to DOH. Incident Managment Coordinator will obtain + Review internal incidat reports filed to assure wheather or not they meet Criteria for reporting to DOH + will assure Submittal. New Policy to be developed	6/30/22 6/30/22

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A 032	Continued From page 10 authority. A copy of the report and the documentation, including the date and time that it was submitted to the licensing authority, shall be maintained on file at the facility. The investigation shall include the following: (1) a narrative description of the incident; (2) the result of the facility's investigation shall be recorded on the state approved incident report form for the current year, pursuant to 7.1.13 NMAC; and (3) plans for further actions in response to the incident. [7.8.2.32 NMAC - Rp, 7.8.2.32 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.32 A (1) 7.1.13 INCIDENT REPORTING, INTAKE, PROCESSING AND TRAINING REQUIREMENTS Refer to 7.1.13.7 W. & 8 B. (2) W. " Reportable incident " means possible abuse, neglect, exploitation, injuries of unknown origin and other events including but not limited to falls which cause injury, unexpected death, elopement), medication error which causes or is likely to cause harm, failure to follow a doctor 's order or an ISP or any other incident which may evidence abuse, neglect, or exploitation . B. (2) Division incident report form and notification by licensed health care facilities: The licensed health care facility shall report incidents utilizing the division's incident report form	A 032	A032 8.2.32 New Policy developed to assure timely reporting + Criteria will address submittal of all incident reports to be completed + reported with in 24 hours or next business day. Carla R.	6/30/22

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A 032	Continued From page 11 consistent with the requirements of the division ' s incident management system guide and CMS regulations as applicable. The licensed health care facility shall ensure that all incident report forms alleging abuse, neglect, exploitation, injuries of unknown origin or other reportable incidents are submitted by a reporter with direct knowledge of an incident, are completed on the bureau's incident report form and received by the division within twenty-four (24) hours of an incident or allegation of an incident or the next business day if the incident occurs on a weekend or a holiday. The licensed health care facility shall ensure that the reporter with the most direct knowledge of the incident assists with the preparation of the incident report form. Based on record review and interview, the facility failed to ensure for 2 (R #s 1 & 5) of 5 (R #s 1-5) residents whose Internal Incident Reports were reviewed for compliance, that incidents of possible abuse, neglect, or exploitation, were reported to the Licensing Authority within 24 hours or the next business day, if it is a weekend or a holiday. This deficient practice could likely result in the residents to be at risk of harm, injury, and/or death, if incidents occur and there is no oversight by the Licensing Authority. The findings are: A. Record review of R #5's Internal Incident Report dated 06/15/21, revealed the following: 1. R #[redacted] 2. R #5[redacted] 3. R #5 was transported to the hospital 4. There was no documentation that the incident was reported to the Licensing Authority	A 032		

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	2216	A. BUILDING: _____ B. WING _____	C 06/02/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE SPIRE ASSISTED LIVING OF RIO RANCHO	1001 24TH ST RIO RANCHO, NM 87124

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A 032	Continued From page 12 B. Record review of R #5's Internal Incident Report dated 06/16/21, revealed the following: 1. R #5 was observed to have [redacted] 2. R #5 was transported to the hospital 3. There was no documentation that the incident was reported to the Licensing Authority C. On 05/19/22 at 9:20 am, during an interview with the House Manager, she confirmed: 1. The resident was sent out from the facility for medical treatment 2. The incidents listed above were not reported to the Licensing Authority within 24 hours or the next business day if it was a holiday or weekend.	A 032		
A 034	7 NMAC 8.2.34 Custodial Drug Permits CUSTODIAL DRUG PERMITS: A facility with two (2) or more residents that is licensed pursuant to this rule and that assists with self-administration or safeguards medications for residents shall have a current custodial drug permit issued by the state board of pharmacy. A. Procurement, labeling and storage. The facility shall provide assistance to the resident in obtaining the necessary medications, treatment and medical supplies as identified in the ISP. The facility shall procure, label and store medications for residents who require assistance with self-administration of medication in compliance with state and federal laws. (1) All medications, including non-prescription drugs, shall be stored in a locked compartment or in a locked room, as approved by the board of pharmacy and the key shall be in the care of the administrator or designee.	A 034	A034 8.2.34 All combustibles will be removed from identified O2 Room. Supplies for residents will be kept in their room. 6/14/22 Oxygen tanks will be stored in proper Oxygen Cylinder Racks upon receipt of delivery of order. 7/1/22 Once Monthly Manager + Maintenance will complete a quality assurance check for safety compliance. CEF	

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A 034	Continued From page 13 (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; (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.	A 034	A034 8.2.34 Managers will be trained to follow policy that all Medication orders are to be entered into EMAR upon receipt. ~~Quarterly~~ Monthly Review will be completed by Med tech + Manager to assure compliance of orders being entered. Upon entering a order Managers will be required to assure delivery of all Medications including ~~PRN~~ including those to be delivered by Pharmacy. New Policy will be developed + staff will be trained. CK	6/30/22

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A 034	Continued From page 14 (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 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]	A 034		

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A 034	Continued From page 15 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 (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	A 034		

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A 034	Continued From page 16 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. 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	A 034		

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A 034	Continued From page 17 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 record review, observation, and interview, the facility failed to ensure: 1. Oxygen cylinder tanks were not stored in a room with combustibles. 2. Oxygen tanks were stored securely and protected from accidental damage or dislocation. 3. Medications with a physician's order were included on the Medication Administration Record (MAR), were in the medication cart, and available to the resident. These deficient practices could likely result in the 28 (R #'s 1-28) residents listed on the resident census, provided by the House Manager on 05/17/22, to be at risk of harm, injury, or death if: 1. Oxygen cylinder tanks were stored with combustibles (plastic bags and plastic tubing) could accelerate the fire. 2. Oxygen cylinder tanks were to fall over damaging the valve, causing them to depressurize during a fire, the oxygen feeds the fire, causing it to spread faster and/or the cylinder tanks act like missiles and hit a resident/staff/rescuer during a fire. 3. Residents were to miss doses or treatments because the medications prescribed by the physicians were not available. The findings are: Findings relate to oxygen A. On 05/18/22 at 1:41 pm, during observation of	A 034		

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A 034	Continued From page 18 the oxygen storage room, the following was observed: 1. 16 tall oxygen cylinder tanks stored in a shallow blue crate that does not protect them from toppling over. 2. 2 oxygen cylinder tanks were unsecured in a crate and toppled over. 3. Plastic bags (combustibles) containing oxygen tubing. B. On 05/23/22 at 12:30 pm, during an interview with the House Manager, she confirmed that the: 1. Oxygen cylinder tanks in the oxygen storage room were unsecured and could fall over and be damaged. 2. Combustibles were being stored with the oxygen in the oxygen storage room. Findings related to medication C. Record review of R #4's Physician Orders dated [redacted] 22, revealed [redacted] was prescribed [redacted] 22, and it was not on the MAR. D. On 05/19/22 at 8:45 am, during observation of the medication cart, no [redacted] was found for R #4. E. Record review of R #4's Medication Administration Record revealed [redacted] was prescribed [redacted] F. On 05/19/22 at 8:45 am, during observation of the medication cart, no Advil Sinus Congestion and Pain was found for R #4. G. On 05/19/22 at 9:15 am, during an interview with DCS #4, she confirmed there was no [redacted] for R #4 in	A 034		

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A 034	Continued From page 19 the medication cart.	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 period and indicate under what circumstances the primary care practitioner (PCP) is to be notified.	A 035	A035 8.2.35 All Staff assisting with Medication delivery will recieve training on completing MARS once the medication has been assisted with. If Medication delivery time has been changed by a order of physician the MARS should reflect its delivery + time of delivery immediately. New Policy will be developed + implemented to reflect administration by outside agency Nurse + change in delivery time by outside nurse. At end of shift MedTech will perform audit of Narcotics (delivered) via Narc log to assure documentation in EMAR. 6/30/22	

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A 035	Continued From page 20 (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 drug; (7) the dosage of the medication;	A 035		

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A 035	Continued From page 21 (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. K. Prescription medication, other than blister packs and unit dose containers, shall be kept in	A 035		

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A 035	Continued From page 22 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 (16) Based on record review, observation, and interview, the facility failed to ensure for 1 (R #1) of 4 (R #s 1-4) residents, that the Medication Administration Record (MAR) included the initials and signature of the Direct Care Staff (DCS) assisting residents with the self-administrator of medications. This deficient practice could likely result in harm to residents if it is unknown if they have received their prescribed medications. The	A 035		

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A 035	Continued From page 23 findings are: A. Record review of R #1's 05/01/22 through 05/17/22 MAR, revealed there was no staff initials for [redacted] B. Record review of R #1's controlled medication count sheet for [redacted] revealed the resident received a [redacted] on 05/17/22 at 6:00 pm and was signed as given by DCS #4. C. On 05/19/22 at 9:52 am, during an interview with DCS #4, she stated: 1. She assisted R #1 with [redacted] at 6:00 pm on 05/17/22 at 6:00 pm. 2. She did not take the medication. 3. She may have forgotten to initial the MAR. D. On 05/19/22 at 9:56 am, during an interview with the Administrator, she stated: 1. R#1 has had some changes to [redacted] and this may have caused some confusion. 2. She does not believe DCS #4 took the medication, but possibly forgot to initial the MAR.	A 035		
A 036	7 NMAC 8.2.36 Nutrition NUTRITION: The facility shall provide planned and nutritionally balanced meals from the basic food groups in accordance with the " 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	A 036	A036 8.2.36 Managers + kitchen chefs or cooks as well as dining servers are to assure that lids are kept on trash cans in kitchen + dining proximity chef are to perform open + close kitchen inspection for compliance -cont-	

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A 036	Continued From page 24 guidelines for Americans. " Vending machines shall not be considered a source of snacks. A. Dietary services policies and procedures. The facility will develop and implement written policies and procedures that are maintained on the premises and that govern the following requirements. (1) Meal service. The facility shall: (a) serve at least three (3) meals or their equivalent each day at regular times with no more than sixteen (16) hours between the evening meal and morning meal with snacks freely available; (b) provide snacks of nourishing quality and post on the daily menu; (c) develop menus enjoyed by the residents and served at normal intervals appropriate to the residents ' preferences; (d) post the weekly menu, including snacks where residents and families are able to view it; posted menus shall be followed and any substitution shall be of equivalent nutritional value and recorded on the posted menu; identical menus shall not be used within a one (1) week cycle; (e) have special menus or meal items following guidelines from the resident ' s physician for residents who have medically prescribed special diets; (f) serve all residents in a dining room except for residents with a temporary illness, or with documented specific personal preference to have meals in their room; (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.	A 036	Chefs will be trained & New policy developed to assure compliance w safe & sanitary storage of refuse. Chefs will maintain compliance of freezer temp by quality checks daily & documentation on daily log. Chefs will recieve additional training on compliance for properly stored foods to assure health & safety of residents.	6/5/22 6/5/22 7/15/22

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A 036	Continued From page 25 (2) Staff in-service training. The facility shall provide an in-service training program for staff that are involved in food preparation at orientation and at least annually and that includes: (a) instruction in proper food storage; (b) preparation and serving food; (c) safety in food handling; (d) appropriate personal hygiene; and (e) infectious and communicable disease control. B. Dietary records. The facility shall maintain the following documentation onsite: (1) a systematic record of all menus and revisions, including snacks, for a minimum of thirty (30) calendar days; (2) a systematic record of therapeutic diets as prescribed by a PCP; (3) a copy of the most recent licensing inspection and for facilities with 10 or more residents, a copy of the New Mexico environment department inspection with notations made by the facility of action taken to comply with recommendations or citations; and (4) a daily log of the recorded temperatures for all facility refrigerators, freezers and steam tables maintained and available for inspection for thirty (30) calendar days. C. Clean and sanitary conditions. All practices shall be in accordance with the standards of the state environment department, pursuant to 7.6.2 NMAC. (1) Kitchen sanitation. (a) Equipment and work areas shall be clean and in good repair. Surfaces with which food or 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.	A 036		

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A 036	Continued From page 26 (c) The walls, ceiling and floors of all rooms that food or drink is stored, prepared or served shall be kept clean and in good repair. (2) Washing and sanitizing kitchenware. (a) All reusable tableware and kitchenware shall be cleaned in accordance with procedures that include separate steps for prewashing, washing, rinsing and sanitizing. (b) Proper dishwashing procedures and techniques shall be utilized and understood by the dishwashing staff. (c) Periodic monitoring of the operation of the detergent dispenser, washing, rinsing and sanitizing temperatures shall be performed and documented. (d) When a dishwashing machine is utilized, the cleanliness of the machine, its jets and its thermostatic controls shall be monitored and documented by the facility. A monthly log of the recorded temperature of the dishwasher shall be maintained in the facility and available for inspection. (3) Sinks for hand washing shall include hot and cold running water, hand-washing soap and disposable towels. (4) All garbage and kitchen refuse that is not disposed of through a garbage disposal unit shall be kept in watertight containers with close-fitting covers and disposed of daily in a safe and sanitary manner. (5) Cooks and food handlers shall wear clean outer garments and hair nets or caps and shall keep their hands clean at all times when engaged 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	A 036		

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A 036	Continued From page 27 conditions and in accordance with the regulations governing food establishments of local health authority having jurisdiction, 7.6.2 NMAC. (1) The facility shall ensure that a minimum of a three (3) calendar day supply of perishables and a five (5) calendar day supply of non-perishables or canned foods is available for the residents. (2) The facility refrigerator and freezer shall have an accurate thermometer which reads within or not more than plus or minus three (3) degrees fahrenheit of the required temperature, located in the warmest section of the refrigerator and freezer and shall be accessible and easily read. (a) The temperature of the refrigerator shall be thirty-five (35) - forty-one (41) degrees fahrenheit. (b) Freezer temperatures shall be maintained at zero (0) degrees fahrenheit or below. (3) Refrigerators and freezers shall be kept clean and sanitary at all times. Food stored in refrigerators and freezers shall be covered, dated and labeled. Unused leftover food shall be discarded after three (3) calendar days. (4) Steam tables, hot food tables, slow cookers, crock pots and other hot food holding devices shall not be used in heating or reheating food. Hot food temperatures shall be checked periodically to insure that a minimum of one hundred forty (140) degrees fahrenheit is maintained. (5) Medication, biological specimens, poisons, detergents and cleaning supplies shall not be kept in the same storage areas used for storage of foods. Medications shall not be stored in the 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	A 036		

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A 036	Continued From page 28 does not preclude the use of local fresh produce. The facility shall not use home-canned foods. (7) Dry or staple food items shall be stored at least six (6) inches off the floor in a ventilated room that is not subject to sewage, waste water back-flow or contamination by condensation, leakage, rodents or vermin. (8) The facility shall ensure the following: (a) all perishable food is refrigerated and the temperature is maintained no higher than forty-one (41) degrees fahrenheit; (b) the temperature for all hot foods is maintained at one hundred forty (140) degrees fahrenheit; and (c) all displayed or transported food is protected from environmental contamination and maintained at proper temperatures in clean containers, cabinets or serving carts. E. Milk. (1) Raw milk shall not be used. (2) Condensed, evaporated, or dried milk products that are nationally recognized may be employed as " additives " in cooked food preparation but shall not be substituted or served to residents in place of milk. F. Collateral requirements. Compliance with this rule does not relieve a facility from the responsibility of meeting more stringent municipal regulations, ordinances or other requirements of state or federal laws governing food service establishments. Local health authority having jurisdiction means municipal, county, state or federal agency(s) that have laws and regulations 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]	A 036		

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A 036	Continued From page 29 This REQUIREMENT is not met as evidenced by: 7.8.2.36 C (4) D (3) (b) (3) Based on observations and interview the facility failed to ensure that the: 1. (1) trash can in the kitchen had a close fitting lid. 2. Temperatures in the facility freezers were kept at zero (0) degrees Fahrenheit (F) or below, plus or minus three (3) degrees. 3. Foods stored in the kitchen and pantry were appropriately covered, dated, labeled, and stored away from chemicals and environmental hazards. This deficient practice could likely result in the 28 (R #s 1- 28) residents identified on the census provided by House Manager on 05/17/22, to be at risk of contracting foodborne illness and needing medical attention if residents consume foods that are not kept at safe temperatures or by ingesting food contaminated by bacteria and germs. The findings are: A. On 05/18/22 at 1:50 pm, during observation and tour of the facility, the facility's reach-in refrigerator had the following items that were not marked with a date in which they were opened, used, and/or placed in the reach-in refrigerator: 1. (1) One opened (1) one gallon plastic jug of milk. 2. (2) Two opened (5) five pound bag of shredded cheese. 3. (1) One rectangular opened block of cream cheese. 4. (1) One opened (1) pound of sandwich meat.	A 036		

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A 036	Continued From page 30 B. On 05/18/22 at 1:55 pm, during observation and tour of the facility, one (1) trash can in the kitchen was observed to not have a close fitting cover. C. On 05/19/22 at 11:34 am, during observation of the facility's kitchen freezer thermometer, revealed that the temperature was recorded at 25 degrees F and was not at zero (0) degrees F or below, plus or minus 3 degrees. This should be in chronological order after finding C, please move. D. On 05/19/22 at 2:25 pm, during an interview with the House Manager, she confirmed the following: 1. (1) trash can in the kitchen did not have a close fitting cover. 2. The facility kitchen freezer thermometer revealed a temperature that was 25 degrees F and not at zero (0) degrees F or below, plus or minus 3 degrees. E. On 05/23/22 at 12:30 pm, during an interview with the House Manager, she confirmed facility's reach-in refrigerator had the above items that were not marked with a date in which they were opened, used, and/or placed in the reach in refrigerator.	A 036		
A 047	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	A 047	A047 8.2.47 Maintanece Man will be required to perform Weekly Emergency light tests. Documentation to be submitted to safety committe Monthly lights are currently working and in order.	6/15/22

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A 047	Continued From page 31 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 28 (R #s 1-28) residents identified on the census provided by the House Manager on 05/17/22 to be at risk of harm, injury, or death, if there is a power outage or other emergency requiring evacuation occurs and the residents cannot see to safely exit the building. The findings are:	A 047		

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A 047	Continued From page 32 A. On 05/18/22 at 1:18 pm, during observation and testing of the facilities emergency lights, the emergency light in the Northeast Hall of the West Lounge failed to light up when tested. B. On 05/19/22 at 2:35 pm, during an interview with the House Manager, she confirmed that the facilities emergency light located in the Northeast Hall of the West Lounge was not in working order.	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 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	A 059	A059 8.2.59 Maintrance will complete quality + Safety check on all units including windows + screens monthly. Documentation to be submitted to Safety committe by end of month. —bdl Window Screens have been measured + ordered. —bf	6/15/22 8/1/22

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A 059	Continued From page 33 by: 7.8.2.59 B Based on observation and interview the facility failed to ensure that all of the facility's windows had screens and that they were in good repair. This deficient practice could likely result in the 28 (R #s 1-28) residents identified on the census provided by the House Manager on 05/17/22, to be at risk of injury or illness if they are exposed to bugs/insects, allergens, or debris coming in through the damaged and missing window screens. The findings are: A. On 05/18/22 at 2:04 pm, during observation of the exterior of the facility the following was observed: 1. Resident room number 22 window did not have a screen. 2. Resident room numbers 7, 8, 9, 18, 21 had bent window screens that created gaps between the window frame and screen. 3. Resident room number 17 window screen was torn along the bottom. B. On 05/19/22 at 2:37 pm, during an interview with the House Manager, she confirmed the resident room window screen findings listed above.	A 059		
A 068	7 NMAC 8.2.68 Hospice HOSPICE: An assisted living facility that provides or coordinates hospice care and services shall meet the requirements in this section, in addition to the rules applicable to all assisted living facilities, 7.8.2 NMAC. A. Definitions: in addition to the requirements for all assisted living facilities pursuant to "	A 068	A068 8.2.68 Life Spire will develop an internal training program on hospice to help address the 4 hr. requirement. This training will be in conjunction with Hospice	

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A 068	Continued From page 34 DEFINITIONS, " 7.8.2.7 NMAC, the following definitions shall also apply. (1) " Hospice agency " means an organization, company, for-profit or non-profit corporation or any other entity which provides a coordinated program of palliative and supportive services for physical, psychological, social and the option of spiritual care of terminally ill people and their families. The services are provided by a medically directed interdisciplinary team in the person's home and the agency is required to be licensed pursuant to 7.12 NMAC. (2) " Hospice care " means a focus on palliative, rather than curative care. The goal of the plan of care is to help the patient live as comfortably as possible, with emphasis on eliminating or decreasing pain and other uncomfortable symptoms. (3) " Licensed assisted living provider " means a facility that provides twenty-four (24) hour assisted living and is licensed by the department of health. (4) " Hospice services " means a program of palliative and supportive services which provides physical, psychological, social and spiritual care for terminally ill patients and their family members. (5) " Care coordination requirements " means a written document that outlines the care and services to be provided by the hospice agency for assisted living residents that require hospice services. (6) " Palliative care " means a form of medical care or treatment that is intended to reduce the severity of disease symptoms, rather than to reverse progression of the disease itself or provide a cure. (7) " Terminally ill " means a diagnosis by a physician for a patient with a prognosis of six (6)	A 068	agency provided training that are on going throughout the year but do not equal to 6 hrs. 6/30/22 HR will assure that 6 hrs are completed per each staff on their ind. year anniversary of employment. Life Spine will develop a certificate of competancy when staff demonstrate knowledge + awareness of Hospice care plans for ind. residents to equal 1 hr. of training	

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A 068	Continued From page 35 months or less to live. (8) " Visit notes " means the documentation of the services provided for hospice residents and includes ongoing care coordination. B. Employee training and support. A facility that provides hospice services shall provide the following education and training for employees who assist with providing these services: (1) provide a minimum of six (6) hours per year of palliative/hospice care training, which includes one (1) hour specific to the hospice resident ' s ISP, in addition to the basic staff education requirements pursuant to 7.8.2.17 NMAC; and (2) offer an ongoing employee psychological support program for end of life care issues. C. Individual service plan (ISP) requirements. (1) Each resident who receives hospice services shall be provided the necessary palliative care to meet the individual resident ' s needs as outlined in the ISP and shall include one (1) hour of training specific to the resident for all direct care staff. (2) The assisted living facility, in coordination with the hospice provider, shall create an ISP that identifies how the resident's needs are met and includes the following: (a) the requirements set forth in the " Individual Service Plan, " 7.8.2.26 NMAC, and " Exceptions to admission, readmission and retention, " Subsection C of 7.8.2.20 NMAC; (b) what services are to be provided; (c) who will provide the services; (d) how the services will be provided; (e) a delineation of the role(s) of the hospice provider and the assisted living facility in the ISP process; (f) documentation (visit notes) of the care and services that are provided with the signature of the person who provided the care and services;	A 068		

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A 068	Continued From page 36 and (g) a list of the current medications or biologicals that the resident receives and who is authorized to administer them. (3) Medications shall be self-administered, self-administered with assistance by an individual that has completed a state approved program in medication assistance or administered by the following individuals: (a) a physician; (b) a physician extender (PA or NP); (c) a licensed nurse (RN or LPN); (d) the resident if their PCP has approved it; (e) family or family designee; and (f) any other individual in accordance with applicable state and local laws. D. Care coordination. (1) The assisted living facility shall be knowledgeable with regard to the hospice requirements pursuant to 7.12 NMAC and ensure that the hospice agency is well informed with regard to the assisted living provisions pursuant to Subsection C of 7.8.2.20 NMAC. (2) The assisted living facility shall hold a team meeting prior to accepting or retaining a hospice resident in accordance with " Exceptions to admission, readmission and retention, " Subsection C of 7.8.2.20 NMAC. (3) Upon admission of a resident into hospice care, the assisted living facility shall designate a section of the resident ' s record for hospice documentation. (a) The facility shall provide individual records for each resident. (b) The hospice agency shall leave documentation at the facility in the designated section of the resident ' s record. (4) The assisted living facility shall provide the resident and family or surrogate decision maker	A 068		

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	2216	A. BUILDING: _____ B. WING _____	C 06/02/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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A 068	Continued From page 37 with information on palliative care and shall support the resident ' s freedom of choice with regard to decisions. (5) Hospice services shall be available twenty-four (24) hours a day, seven (7) days a week for hospice residents, families and facility staff and may include continuous nursing care for hospice residents as needed. These services shall be delivered in accordance with the resident ' s individual service plan (ISP) and pursuant to 7.8.2 26 NMAC. (6) The assisted living facility shall ensure the coordination of services with the hospice agency. (a) The resident's individual service plan (ISP) shall be updated with significant changes in the resident ' s condition and care needs. (b) The assisted living facility shall receive information and communication from the hospice staff at each visit. (i) The information shall include the resident status and any changes in the ISP (i.e., medication changes, etc.). (ii) The information shall be in the form of a verbal report to the assisted living facility staff and also in the form of written documentation. (c) The assisted living facility or the family/resident shall reserve the right to schedule care conferences as the needs of the resident and family dictate. The care conferences shall include all care team members. (d) Concerns that arise with regard to the delivery of services from either the assisted living facility or the hospice agency shall first be addressed with the facility administrator and the hospice agency administrator. (i) The process may be informal or formal depending on the nature of the issue. (ii) If an issue can not be resolved or if there is an immediate danger to the resident the appropriate	A 068		

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A 068	Continued From page 38 authority shall be notified. E. Additional provisions. An assisted living facility that provides or coordinates hospice care and services shall make additional provisions for the following requirements: (1) individual services and care: each resident receiving hospice services shall be provided the necessary palliative procedures to meet individual needs as defined in the ISP; (2) private visiting space: (a) physical space for private family visits; (b) accommodations for family members to remain with the patient throughout the night; and (c) accommodations for family privacy after a resident ' s death. F. Medicare and medicaid restrictions. Assisted living facilities shall not accept a resident considered " hospice general inpatient " which would be billable to medicare or medicaid because the facility will not qualify for payment by medicare or medicaid. [7.8.2.68 NMAC - N, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.68 B (1) Based on record review and interview, the facility failed to ensure that Direct Care Staff (DCS) had received the required six (6) hours of palliative/hospice training including one hour specific to resident's Individual Service Plan (ISP) annually when the facility is providing care and services for hospice residents. This deficient practice could likely result in the 15 (R #s 1, 6, 8, 9, 11, 12, 14, 17, 18, 19, 21, 22, 24, 26, 28) residents identified as receiving hospice services by the Administrator on 05/17/22, to be	A 068		

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A 068	Continued From page 39 at risk of harm or injury if the DCS do not know the proper methods of providing care and services. The findings are: A. Record review of DCS #1's employee file (date of hire 04/11/20), revealed only 1.5 hours of palliative/hospice training was completed annually. B. Record review of DCS #4's employee file (date of hire 04/20/18), revealed only 0.5 hours of palliative/hospice training was completed annually. C. Record review of the House Manager's employee file (date of hire 07/10/17), revealed only 1.5 hours of palliative/hospice training was completed annually. D. On 05/20/22 at 2:41 pm, during an interview with the House Manager, she confirmed that DCS #'s 1, 4, and herself had not completed the required 6 hours of palliative/hospice training annually.	A 068		
A 069	7 NMAC 8.2.69 Memory Care Units MEMORY CARE UNITS: An assisted living facility that provides a memory care unit to serve residents with dementia shall comply with the provisions of subsection A-J below in addition to the rules applicable to all assisted living facilities, 7.8.2 NMAC. A. Additional definitions: The following definitions, in addition to those in 7.8.2.7 NMAC, shall apply. (1) " Alzheimer ' s " means a brain disorder that destroys brain cells, causing problems with memory, thinking and behavior that are severe enough to affect work, lifelong hobbies or social	A 069	A069 8.2.69 LifeSpire is not categorized as a memory care unit, but due to securing the premisis for safety reasons it is newly discovered that we must adhere to the 12 hrs of training. LifeSpire will implement training	

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A 069	Continued From page 40 life. Alzheimer ' s gets progressively worse and is fatal. (2) " Care coordination agreement requirement " means a written document that outlines the care and services that are provided by other outside agencies for assisted living residents that require additional care and services. (3) " Dementia " means loss of memory and other mental abilities severe enough to interfere with daily life. It is caused by changes in the brain. (4) " Memory care unit " means an assisted living facility or part of or an assisted living facility that provides added security, enhanced programming and staffing appropriate for residents with a diagnosis of dementia, Alzheimer ' s disease or other related disorders causing memory impairments and for residents whose functional needs require a specialized program. (5) " Secured environment " means locked (secured/monitored) doors/fences that restrict access to the public way for residents who require a secure unit. B. Care coordination requirement. An assisted living facility that accepts residents with memory issues shall determine which additional services and care requirements are relevant to the resident and disease process. (1) The medical diagnosis and ISP shall be utilized in the determination of the need for additional services. (2) The assisted living facility shall ensure the coordination of services and shall have evidence of an agreement of care coordination for all services provided in the facility by an outside health care provider. C. Employee training. In addition to the training requirements for all assisted living facilities, pursuant to 7.8.2.17 NMAC, all employees	A 069	programs to demonstrate 12 hrs of annual alzheimers + dementia training. all current staff will be trained for 4 hrs per quarter for a total of 12 per year. Begins June 30th 2022. On Line training + trainings by Certified Dementia Practioner may be developed. as well. HR to perform Quarterly Personal files checks to assure compliance + certificates demonstrating training on file.	6/30/22

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A 069	Continued From page 41 assisting in providing care for memory unit residents shall have a minimum of twelve (12) hours of training per year related to dementia, Alzheimer ' s disease, or other pertinent information. D. Individual service plan (ISP). An assisted living facility that admits memory care unit residents shall create an ISP in coordination with the resident ' s primary care practitioner, in compliance with the requirements outlined in " Individual Service Plan, " 7.8.2.26 NMAC, pursuant to a team meeting as described in " Exceptions to admission, readmission and retention, " Subsection C of 7.8.2.20 NMAC, and which ensures the following criteria: (1) identification of the resident's needs specific to the memory care unit and the services that are provided; each memory unit resident shall receive the services necessary to meet the individual resident ' s needs; (2) medications shall be self-administered, self-administered with assistance by an individual that has completed a state approved program in medication assistance or administered by the following individuals: (a) a physician; (b) a physician extender (PA or NP); (c) a licensed nurse (RN or LPN); (d) the resident if their PCP has approved it; (e) family or family designee; and (f) any other individual in accordance with applicable state and local laws. E. Assessments and reevaluations. (1) An assessment shall be completed by a registered nurse or a physician extender within fifteen (15) days prior to admission. When emergency placement is warranted the fifteen (15) day assessment shall be waived and the assessment shall be completed within five (5)	A 069	No comments Noted on this page. CRV —	

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A 069	Continued From page 42 days after admission. (a) The resident shall have a medical evaluation and documentation by a physician, physician's assistant or a nurse practitioner within six (6) months of admission. (b) The pre-admission assessment shall include written findings, an evaluation of less restrictive alternatives and the basis for the admission to the secured environment. The written documentation shall include a diagnosis from the resident's PCP of Alzheimer's disease or other dementia and the need for the resident to reside in a memory care unit. (c) Only those residents who require a secured environment placement or whose needs can be met by the facility, as determined by the assessment prior to admission or on review of the individual service plan (ISP), shall be admitted. (2) A re-evaluation must be completed every six (6) months and when there is a significant change in the medical or physical condition of the resident that warrants intervention or different care needs, or when the resident becomes a danger to self or others, to determine whether the resident ' s stay in the assisted living facility memory care unit is still appropriate. F. Documentation in the resident ' s record. In addition to the required documentation pursuant to 7.8.2.21 NMAC, the following information shall be documented in the resident ' s record: (1) the physician ' s diagnosis for admission to a secure environment or a memory care unit; (2) the pre-admission assessment; and (3) the re-evaluation(s). G. Secured environment. (1) Memory care unit residents may require a secure environment for their safety. A secured environment is any locked (secured/monitored)	A 069		

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A 069	Continued From page 43 area in which doors and fences restrict access to the public way. These include but are not limited to: (a) double alarm systems; (b) gates connected to the fire alarm; and (c) tab alarms for residents at risk for elopement. (2) In addition to the interior common areas required by this rule, the facility shall provide a safe and secure outdoor area for the year round use by the residents. (a) Fencing or other enclosures shall prevent elopement and protect the safety and security of the residents. (b) Residents shall be able to independently access the outdoor areas. (3) Locked areas shall have an access code or key which facility employees shall have available on their person or on the locking unit itself at all times. H. Resident rights. In addition to the requirements pursuant to 7.8.2.32 NMAC, the following shall apply: (1) the resident's rights may be limited as required by their condition and as identified in the ISP; (2) the resident who believes that he or she has been inappropriately admitted to the secured environment may request the facility in contact the resident ' s legal guardian, or an advocate such as the ombudsman or the primary care practitioner; upon request, the facility shall assist the resident in making such contact. I. Disclosure to residents. A facility that operates a secured environment shall disclose to the resident and the resident ' s legal representative, if applicable and prior to the resident ' s admission to the facility, that the facility operates a secured environment. (1) The disclosure shall include information about	A 069		

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A 069	Continued From page 44 the types of resident diagnosis or behaviors that the facility provides services for and for which the staff are trained to provide care for. (2) The disclosure shall include information about the care, services and the type of secured environment that the facility and trained staff provide. J. Staffing. The facility shall provide the sufficient number of trained staff members to meet the additional needs of the residents in the secured environment. There must be at least one (1) trained staff member awake and in attendance in the secured environment at all times. [7.8.2.69 NMAC - N, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.69 C Based on record review and interview, the facility failed to ensure that Direct Care Staff (DCS) had completed the required 12 hours of Alzheimer's/Dementia training annually. This deficient practice could likely result in the 18 (R #s 2-4, 6-11, 15, 17-21, 24, 26, 27) residents identified as receiving Alzheimer's/dementia (diseases negatively affecting memory, behavior, and thinking) care services by the Administrator on 05/17/22, to be at risk of harm or injury if DCS do not know the proper methods of providing care and services. The findings are: A. Record review of DCS #1's employee file (date of hire 04/11/20), revealed there was only 0.5 hours of Alzheimer/Dementia training completed annually. B. Record review of DCS #4's employee file (date of hire 04/20/18), revealed there was only	A 069		

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A 069	Continued From page 45 1.5 hours of Alzheimer/Dementia training completed annually. C. Record review of the House Manager's employee file (date of hire 07/10/17), revealed there was only 0.5 hours of Alzheimer/Dementia training completed annually. D. On 05/20/22 at 2:41 pm, during an interview with the House Manager, she confirmed that DCS #'s 1, 4, and herself had not completed the required 12 hours of Alzheimer/Dementia training annually.	A 069		