Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2218	A. BUILDING: _____ B. WING _____	C 09/30/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HACIENDAS AT GRACE VILLAGE, LLC - UNIT B	2802 CORTE DIOS LAS CRUCES, NM 88011

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 000	Initial Comments The following deficiencies were cited during a Full-Onsite survey completed on 09/30/22 for the state requirements of 7 NMAC 8.2, Regulations for Assisted Living for Adults. DCS - Direct Care Staff EAR - Employee abuse registry CCHSP - Caregivers Criminal History Screening Act R- Resident	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	A 016	**The facility will continue to adhere to policies 7.8.2.16, 7.1.12.8 and 7.1.9.8 (Staff Qualification, Employee Abuse Registry, caregiver and Hospital Caregiver Employment requirements, and NM Caregiver Criminal). Facility will ensure all NM Caregiver Criminal History Screening will be done prior to employment. And all documentation will be kept in their personal file. An audit is in progress as of Oct 10, 2022,and will be completed by Oct. 31, 2022.** **The administrator or designee will monitor.** **An audit will be conducted quarterly.**	

Division of Health Improvement
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE Admin (X6) DATE 11/3/22

Division of Health Improvement

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A 016	Continued From page 1 (9) comply with the pre-employment requirements 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.	A 016		

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A 016	Continued From page 2 [7.8.2.16 NMAC - Rp, 7.8.2.16 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.16. B (3) (7) Refer to 7.1.12 EMPLOYEE ABUSE REGISTRY 7.1.12.8 REGISTRY ESTABLISHED; PROVIDER INQUIRY REQUIRED: Upon the effective date of this rule, the department has established and maintains an accurate and complete electronic registry that contains the name, date of birth, address, social security number, and other appropriate identifying information of all persons who, while employed by a provider, have been determined by the department, as a result of an investigation of a complaint, to have engaged in a substantiated registry-referred incident of abuse, neglect or exploitation of a person receiving care or services from a provider. Additions and updates to the registry shall be posted no later than two (2) business days following receipt. Only department staff designated by the custodian may access, maintain and update the data in the registry. A. Provider requirement to inquire of registry. A provider, prior to employing or contracting with an employee, shall inquire of the registry whether the individual under consideration for employment or contracting is listed on the registry. B. Prohibited employment. A provider may not employ or contract with an individual to be an employee if the individual is listed on the registry as having a substantiated registry-referred incident of abuse, neglect or exploitation of a person receiving care or services from a provider.	A 016		

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

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A 016	Continued From page 4 the registry. Such sanctions may include a directed plan of correction, civil monetary penalty not to exceed five thousand dollars ($5000) per instance, or termination or non-renewal of any contract with the department or other governmental agency. [7.1.12.8 NMAC - N, 01/01/2006] Refer to 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 support activities required by the Act and these	A 016		

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A 016	Continued From page 5 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 effective date of a contractual relationship with	A 016		

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A 016	Continued From page 6 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: 1. DCS received clearances from the EAR prior to their hire dates. 2. DCS had their applications and fingerprints for the CCHSP submitted within 20 days of hire. This deficient practice could likely have a negative affect on the safety and welfare of the 10 (R #s 1-10) residents identified on the census provided by the Office Manager on 09/27/22, if residents are being provided care by staff who may have a previous history of abusing, neglecting, and/or exploiting residents and who may have a previous criminal history.	A 016		

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A 016	Continued From page 7 The findings are: A. Record review of DCS #11's employee file (hire date 09/12/22) revealed: 1. The EAR clearance was not submitted and/or received until 10/10/22 2. The application for fingerprints was not submitted until 10/10/22. C. On 09/30/22 at 10:30 am, during an interview with the Administrator, she confirmed: 1. The EAR clearance for DCS #11 was not received prior to hire on 09/12/22. Did not have the EAR or fingerprint application until 10/10/22. 2. The application and fingerprints for DCS #11 were not submitted to the CCHSP within 20-days of hire.	A 016		
A 017	7 NMAC 8.2.17 Staff Training STAFF TRAINING: A. Training and orientation for each new employee and volunteer that provides direct care shall include a minimum of sixteen (16) hours of supervised training prior to providing unsupervised care for residents. B. Documentation of orientation and subsequent trainings shall be kept in the personnel file at the facility. C. Training shall be provided at orientation and at least twelve (12) hours annually, the orientation, training and proof of competency shall include: (1) fire safety and evacuation training; (2) first aid; (3) safe food handling practices (for persons involved in food preparation), to include: (a) instructions in proper storage; (b) preparation and serving of food; (c) safety in food handling;	A 017	**The facility will continue to ensure that the direct care staff will receive all the required orientation and annual training. The facility will put more focus on the documentation of current in-service training, document individual participation in the training more closely, and track attendance. Random audits will be conducted, a new tracking log will be created (a spreadsheet with all new hires date and checklist of completion).** **The administrator or designee with monitor.** **Facility started audit on Oct 10, 2022. An audit will be conducted quarterly.**	

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A 017	Continued From page 8 (d) appropriate personal hygiene; and (e) infectious and communicable disease control; (4) confidentiality of records and resident information; (5) infection control; (6) resident rights; (7) reporting requirements for abuse, neglect or exploitation in accordance with 7.1.13 NMAC; (8) smoking policy for staff, residents and visitors; (9) methods to provide quality resident care; (10) emergency procedures; (11) medication assistance, including the certificate of training for staff that assist with medication delivery; and (12) the proper way to implement a resident ISP for staff that assist with ISPs. D. If a facility provides transportation to residents, employees of the facility who drive vehicles and transport residents shall have training in transportation safety for the elderly and disabled, including safe vehicle operation. [7.8.2.17 NMAC - Rp, 7.8.2.17 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.17 A B C (1 - 12) Based on record review and interview, the facility failed to ensure that the (DCS) Direct Care Staff training files included complete documentation of the DCS receiving and completing 16 hours supervised training prior to providing unsupervised resident care and of completing the required 12 hours of orientation training, with proof of competency. This deficient practice could likely result in the 10 (R #s 1-10) residents listed on the resident	A 017		

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A 017	Continued From page 9 census, provided by the Administrator on 09/27/22, to be at risk of harm if they are receiving care and services by DCS who have not received the required trainings. The findings are: A. Record review of DCS #10s employee file (hire date 07/28/22), revealed no documentation of the following training requirements with proof of competency: 1. Sixteen (16) hours of supervised training prior to providing unsupervised care for residents. 2. Completion of an acceptable Medication Assistance training course. 3. Twelve (12) hours of training at orientation, with proof of competency. B. Record review of DCS #11s employee file (hire date 01/06/22), revealed no documentation of the following training requirements with proof of competency: 1. Sixteen (16) hours of supervised training prior to providing unsupervised care for residents. 2. Completion of an acceptable medication assistance training course. 3. Twelve (12) hours of training at orientation with proof of competency. C. On 09/27/22 at 09:27 am, during an interview with the Administrator, she confirmed that DCS #s 10 and 11 staff files did not contain documentation of the DCS completing required training that included: 1. Sixteen (16) hours of supervised training prior to providing unsupervised care for residents. 2. An acceptable medication assistance training course. 3. Twelve (12) hours of training at Orientation with proof of competency.	A 017		

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A 025	Continued From page 10	A 025		
A 025	7 NMAC 8.2.25 Resident Evaluation RESIDENT EVALUATION: A. A resident evaluation shall be completed by an appropriate staff member within fifteen (15) days prior to admission to determine the level of assistance that is needed and if the level of services required by the resident can be met by the facility. B. The initial resident evaluation shall establish a baseline in the resident ' s functional status and thereafter assist with identifying resident changes. The resident evaluation shall be reviewed and updated at a minimum of every six (6) months or when there is a significant change in the resident ' s health status. C. The resident ' s evaluation shall be documented on a resident evaluation form and at a minimum include the following abilities, behaviors or status: (1) activities of daily living; (2) cognitive abilities; reasoning and perception; the ability to articulate thoughts, memory function or impairment, etc; (3) communication and hearing; ability to communicate needs and understand instructions, etc; (4) vision; (5) physical functioning and skeletal problems; (6) incontinence of bowel/bladder; (7) psychosocial well-being; (8) mood and behavior; (9) activity interests; (10) diagnoses; (11) health conditions; (12) nutritional status; (13) oral or dental status; (14) skin conditions; (15) medication use and level of assistance	A 025	**The facility will ensure that admission evaluations are completed prior to 15 calendar days of admission. A checklist will also be kept for tracking the 15-calendar day admission completed, along with a 6-month audit or when there are significant changes with a resident or move to a different buildings.** **Campus Nurse or designee with monitor.** **Campus Nurse will continue to audit and update all current resident evaluations and ISPs by 12-20-2022.**	

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A 025	Continued From page 11 needed with medications; (16) special treatments and procedures or special medical needs such as hospice; and (17) safety needs/high risk behaviors; history of falls agitation, wandering, fire safety issues, etc. D. The resident evaluation shall include a history and physical examination and an evaluation report by a physician or a physician extender within six (6) months of admission. A resident shall have a medical evaluation by a physician or a physician extender at least annually. E. The resident evaluation shall be reviewed and if needed revised by a licensed practical nurse, registered nurse or physician extender at the time the individual service plan is reviewed, at a minimum of every six (6) months or when a significant change in health status occurs. [7.8.2.25 NMAC - Rp, 7.8.2.25 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.25 A, B Based on record review and interview, the facility failed to ensure for 3 (R #s 1-3) of 3 (R #s 1-3) residents whose evaluations were reviewed for compliance that they: 1. Were reviewed and updated at a minimum of every six (6) months or when there is a significant change in the resident's health status. 2. Were completed within 15 calendar days of admission. These deficient practices could likely result in the residents not receiving appropriate care/services,	A 025		

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A 025	Continued From page 12 if the Direct Care Staff (DCS) are not aware of what the resident's needs are. The findings are: A. Record review of R #1's (admission date [redacted]15) resident file, revealed that the evaluation (dated 07/18/16) had not been reviewed at a minimum of every six (6) months. B. Record review of R #2's (admission date [redacted]19) resident file, revealed that the evaluation (dated 06/20/20) had not been reviewed at a minimum of every six (6) months. C. Record review of R #3's (admission date [redacted]22) resident file, revealed that the evaluation (03/02/22) had not been completed within 15 calendar days of admission. D. On 09/30/22 at 10:30 am, during an interview with the Nurse, she confirmed: 1. Resident evaluations were not completed and updated at a minimum of every six (6) months. 2. Resident evaluation for R #3 was not completed within 15 calendar days of admission.	A 025		
A 026	7 NMAC 8.2.26 Individual Service Plan INDIVIDUAL SERVICE PLAN (ISP): An ISP shall be developed and implemented within ten (10) 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.	A 026	**The facility will ensure that individual service plans will be developed and implemented within 10 calendar days of admission for each resident per 8.2.26. Individual Service Plan (Care Plans) will be revised per guidelines before the six month deadline or any change of condition.** **Campus Nurse or designee** **Campus Nurse will monitor and audit all individual plans by December 20, 2022.**	

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A 026	Continued From page 13 (2) The resident evaluation and the ISP shall be reviewed and if needed revised by a licensed practical nurse, registered nurse or a physician extender. (3) The ISP shall be reviewed and or revised at a minimum of every six (6) months or when there is a significant change in the resident ' s health status. B. The ISP shall include the following: (1) a description of identified needs as noted in the resident evaluation; (2) a written description of all services to be provided; (3) who will provide the services; (4) when or how often the services will be provided; (5) how the services will be provided; (6) where the services will be provided; (7) expected goals and outcomes of the services; (8) documentation of the facility ' s determination that it is able to meet the needs of the resident; (9) the level of assistance that the resident will require with activities of daily living and with medications; (10) a crisis prevention/intervention plan when indicated by diagnosis or behavior; and (11) current orders for all medications, including those authorized for PRN usage. [7.8.2.26 NMAC - Rp, 7.8.2.26 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.26 A (3) Based on record review and interview the facility failed to ensure for 1 (R #2) of 3 (R #'s 1 - 3) residents whose records were reviewed for	A 026		

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A 026	Continued From page 14 compliance that the Individual Service Plans (ISPs) were 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. These deficient practices could potentially affect the health, safety, and welfare of residents if their ISP's are not reviewed and or revised to verify that DCS are providing the resident appropriate level of assistance with ADLs based on the resident's abilities and due to any significant change in the resident health. The findings are: A. Record review of R #2's [redacted] dated [redacted] 22 had no documentary evidence that the ISP was reviewed and or revised at a minimum of every six (6) months. B. On 09/30/22 at 10:30 am, during an interview with the Administrator, she confirmed that the ISP was not reviewed and or revised at a minimum of every six (6) months.	A 026		
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	A 034	**The facility will adhere to policy 7.8.2.34 by ensuring that all medications doses are administered and/or maintain documentation (ie: Pharmacy medication out-of-stock, physician unavailablitiy, etc)detailing why medications were unable to provided to the resident. All OTC medication will be removed unless specifically ordered by a physician and properly labeled.** **On Oct 14, a new audit tracking log was created. Random inspections and audits will be conducted weekly.** **(continue to next pg)**	

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A 034	Continued From page 15 for residents who require assistance with self-administration of medication in compliance with state and federal laws. (1) All medications, including non-prescription drugs, shall be stored in a locked compartment or in a locked room, as approved by the board of pharmacy and the key shall be in the care of the administrator or designee. (2) Internal medication shall be kept separate from external medications. Drugs to be taken by mouth shall be separated from all other delivery forms. (3) A separate, locked refrigerator shall be provided by the facility for medications. The refrigerator temperature shall be kept in compliance with the state board of pharmacy requirements for medications. (4) All medications, including non-prescription medications, shall be stored in separate compartments for each resident and all medications shall be labeled with the resident's name. (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;	A 034	**(Continued from page 15)** **Administrator or designee will monitor.**	

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A 034	Continued From page 16 (b) the date and time staff assisted with self-administration; (c) the resident ' s name; (d) the prescriber ' s name; (e) the dose; (f) the signature of the person assisting with delivery of the medication; and (g) the balance of medication remaining. (9) Any remaining medication discontinued by a physician ' s order, or upon discharge or death of the resident shall be inventoried and moved to a separate locked storage container. Such discontinued medications shall be destroyed upon the next quarterly visit by the consulting pharmacist in accordance with 16.19.11.10 NMAC. (10) The record of medication destruction shall be signed by the administrator or designee and the pharmacist and shall be kept on file at the facility. B. Consulting pharmacist. The facility shall maintain records demonstrating that the 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.	A 034		

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A 034	Continued From page 17 (4) The consulting pharmacist will be responsible for assuring that the facility meets all requirements for storage, labeling, destruction and documentation of medications as required by the state board of pharmacy, 16.19.11.10 NMAC and 7.8.2 NMAC. [7.8.2.34 NMAC - Rp, 7.8.2.35 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.34 A (4) Based on record review, observation, and interview the facility failed to ensure for 1 (R #1) of 3 (R #s 1-3) residents, that all: 1. Prescribed medications were available at the facility to be taken as ordered. 2. Medications, including over the counter (OTC) medications were labeled with the resident's name This deficient practice could likely result in the residents being at risk of harm, injury and death if: 1. Prescribed medications are not available to be taken when needed and as ordered. 2. If the wrong medication is given to the wrong resident, because the medication was not labled with the resident's name. The findings are: A. Record review of R #1's MARs dated 09/01/22 through 09/27/22, revealed that the following doses of medications were missed, because the medications were not available: [redacted]	A 034		

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A 034	Continued From page 18 [redacted] C. During observation of the medication cart, the facility was providing OTC (over the counter) medication [redacted] to R #1 and it was not labeled with the resident's name. D. On 09/30/22 at 10:26 am, during the exit interview, the Administrator and Nurse, confirmed that R #s 1 medications listed above were not given because the medications needed refills and the Doctor was not able to be reached to refill the medications and that the facility was providing OTC as needed (PRN) medications without proper labeling with the resident's name.	A 034		
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.	A 059	**The facility will adhere to policy 7.8.2.59 to ensure all window locks have been removed on Oct 4, 2022 and broken window screens will be replaced by December 13, 2022. Quarterly audits will be done to ensure screens are in good condition.** **Administrator and designee will monitor.** **This will be monitored quarterly.**	

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A 059	Continued From page 19 (2) The top of the window sill shall not be more than forty-four (44) inches above the finished floor. B. Screens shall be provided on all operable windows. C. The proposed use of bars, grilles, grates or similar devices shall be reviewed and approved by the licensing authority prior to installation. D. Sleeping rooms, living rooms, activity room areas and dining room areas shall have a window area of at least one tenth (1/10) of the floor area with a minimum of ten (10) square feet. [7.8.2.59 NMAC - Rp, 7.8.2.52 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.59 B Based on observation and interview the facility failed to ensure that all of the facility's windows were operable and the windows had properly fitted screens. This deficient practice could likely result in the 10 (R #s 1-10) residents identified on the census provided by the Administrative Assistant on 09/27/22, to be at risk of injury or illness if the windows: 1. Are not able to be opened (bolted) and exited in case of fire or other emergency that require evacuation. 2. Screens are damaged and or do not fit properly exposing residents to bugs/insects, allergens, or debris coming in through the windows. The findings are:	A 059		

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A 059	Continued From page 20 A. On 09/27/22 at 11:24 am, during observation of the exterior of the facility, it was observed, outside of room #1, the window did not have a properly fitted screen and was damaged. B. On 09/27/22 at 11:34 am, during observation of residents rooms, bolt attachments were observed on resident windows in room #'s 4, 5, 6 to prevent them from opening and the bolts were not able to be taken off. C. On 09/27/22 at 3:50 pm, during an interview with the Administrative Assistant, he confirmed that 1. Room #1's screen was damaged and did not fit properly. 2. Bolts were placed on resident windows in room #'s 4, 5, 6 to prevent them from opening.	A 059		
A 065	7 NMAC 8.2.65 Fire Drills FIRE DRILLS: All facilities shall conduct monthly fire drills which are to be documented. A. There shall be at least one (1) documented fire drill per month and at a minimum, one documented fire drill each eight (8) hours (day, evening, night) per quarter that employs the use of the fire alarm system or the detector system in the facility. B. A record of the monthly fire drills shall be maintained on file in the facility and readily available. Fire drill records shall show: (1) the date of the drill; (2) the time of the drill; (3) the number of staff participating in the drill; (4) any problem noted during the drill; and (5) the evacuation time in total minutes. C. If applicable, the local fire department may be requested to supervise and participate in fire	A 065	**The facility confirms compliance with the fire drill regulation as mandated by the NMHD conduct fire drills on a monthly basis. The facility promptly began Oct 3, 2022.** **All staff will participate in actual fire drill and staff training will be provided. Documentation will also be kept for any resident needing additional assistants if needed during a fire drill. And if any other concern (problems) occurs it will also be documented and used for training** **On-going proper fire drill regulation to be followed monthly.** **The Administrator or designee with monitor**	

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A 065	Continued From page 21 drills. [7.8.2.65 NMAC - Rp, 7.8.2.65 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.65 A, B (4) Based on record review and interview, the facility failed to ensure that fire drills: 1. Were conducted each month 2. Any problems experienced during the fire drill were documented. This deficient practice could likely result in the 10 (R #s 1-10) residents identified on the census, provided the Administrator on 09/27/22, to be at risk of harm, injury, or death, if a fire were to occur and the Direct Care Staff (DCS) do not know how to safely evacuate the residents from the building. The findings are: A. Record review of the facility's fire drill records dated for January, 2022 to August, 2022 revealed no documentation that: 1. A fire drill was conducted in the month of July, 2022. 2. No documentation of any problems experienced during the fire drills B. On 09/28/22 at 5:18 pm, during an interview with the Administrator, she confirmed that the Building B fire drill records for January, 2022 to August, 2022 did not include documentation of: 1. A fire drill being conducted in the month of July, 2022. 2. Any problems that may have occurred during the fire drills.	A 065		

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A 066	7 NMAC 8.2.66 Staff and Resident Fire and Safety Training STAFF AND RESIDENT FIRE AND SAFETY TRAINING: A. All staff of the facility shall know the location and the proper use of fire extinguishers and the other procedures to be followed in case of fire or other emergencies. The facility should request the local fire prevention authority to give periodic instructions in the use of fire prevention and techniques of evacuation. B. Facility staff shall be instructed as part of their duties to constantly strive to detect and eliminate potential safety hazards, such as loose handrails, frayed electrical cords, blocked exits or exit-ways and any other condition which could cause burns, falls, or other personal injury to the residents or staff. C. Each new resident admitted to the facility shall be given an orientation tour of the facility to include the location of the exits, fire extinguishers and telephones and shall be instructed in the actions to be taken in case of fire or other emergencies. D. Fire drill procedures. The facility must conduct at least one (1) fire drill each month. (1) Fire drills shall be held at different times of the day, evening and night. (2) The fire alarm system or detector system in the facility shall be used in the fire drills. During the night, the fire drill alarm may be silenced. (3) During the fire drills, emphasis shall be placed upon orderly evacuation under proper discipline rather than upon speed. (4) A record of the conducted fire drills shall be maintained on file in the facility. The record shall show the date and time of the drill, the number of personnel participating in the drill, any problem(s) noted during the drill and the evacuation time in	A 066	**The facility will confirm compliance with the fire drill regulation as mandated by the NMHD to comply with performing fire drills on monthly basis, and cover one per month to assure all shifts are covered every quarter.** **Upon hiring and annually staff will participate in actual education and fire drill training per NMHD 8.2.66.A.S.** **Staff will participate in actual fire drill and staff training will be provided. Documentation will also be kept for any resident needing additional assistants if needed during a fire drill. And if any other concern (problems) occurs it will also be documented and used for training, including fire extinguishers, fire exit, and any other matters that occur.** **On-going proper fire drill regulation to be followed monthly.** **The facility promptly completed a fire inspection on October 6, 2022.** **The Administrator or designee with monitor**	

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A 066	Continued From page 23 total minutes. (5) The local fire department may be requested to supervise and participate in the fire drills. [7.8.2.66 NMAC - Rp, 7.8.2.63 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.66 A B C D (4) Based on record request, record review, and interview the facility failed to ensure that the: 1. Direct Care Staff (DCS) were trained on the procedures to detect and eliminate potential safety hazards, properly use fire extinguishers, evacuation techniques and the other procedures in case of fire or other emergencies. 2. Residents were informed of the location of the facility fire exits, fire extinguishers, telephones and were instructed in what actions to take in case of a fire or other emergency. 3. Any problems that may have occurred during the drill were documented on the Fire Drill Report. These deficient practices could likely result in all 10 (R #s 1-10) residents listed on the census, provided by the Administrator on 09/27/22, to be at risk of harm, injury, or death if a fire or other emergency that required evacuation were to occur, if the: 1. DCS do not know the procedures to follow in order to eliminate safety hazards, how to use a fire extinguishers, or how to orderly evacuate residents from the facility. 2. Residents have not received evacuation training, and do not know how to safely evacuate the facility. 3. DCS are not aware of any problems that may	A 066		

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A 066	Continued From page 24 have occurred during the drill. The findings are: A. Record review of DCS #s 10 and 11 training records, revealed no documentation that the DCS had completed Fire Safety training that included: 1. The procedures to detect and eliminate potential safety hazards. 2. Proper use a fire extinguishers. 3. Evacuation techniques. B. Record review of R #s 1-3 resident records, revealed no documentation that the resident/families fire safety orientation that included: 1. The location of the exits, fire extinguishers, and telephones. 2. Instruction on the actions to take in case of a fire or other emergency. C. Record review of the facility Fire Dill Report dated 08/25/22 at 4:25 pm, revealed no documentation of any problems that may have occurred during the drill. D. On 09/28/22 5:18 pm, during an interview with the Administrator, she confirmed that there was no documentation available for review for the following: 1. Fire Safety training records for DCS #s 1-3 including: a. Completing fire drill training. b. Completing training that included the procedures to detect and eliminate potential safety hazards, c. Being trained on the proper use fire extinguishers. d. Being trained on evacuation techniques. 2. Documentation of R #s 1-3, receiving	A 066		

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HACIENDAS AT GRACE VILLAGE, LLC - UNIT B	2802 CORTE DIOS LAS CRUCES, NM 88011

(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 066	Continued From page 25 orientation training that included: a. The location of the exits, fire extinguishers, and telephones that can be used in an emergency. b. Being instructed in the actions to be taken in case of fire or other emergencies. E. On 09/28/22 at 5:18 pm, during an interview with the Administrator, she confirmed that the facility did not document any problems related to residents evacuating the facility.	A 066		