STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROV DER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	4047	A. BUILDING: _____ B. WING _____	R-C 10/06/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVAMERE AT RIO RANCHO	1000 RIVERVIEW DRIVE SE RIO RANCHO, NM 87124

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{A 000}	Initial Comments The following deficiencies were cited during an offsite Revisit/Follow-up survey completed on 10/06/22 for the state requirements of 7 NMAC 8.2, Regulations for Assisted Living for Adults.	{A 000}		
{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; (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	{A 017}		

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{A 017}	Continued From page 1 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 (1-10) (3 a-e) (4-12) This is an uncorrected deficiency from survey dated 03/08/21. Based on record review and interview the facility failed to ensure that the Direct Care Staff (DCS), received the following required (12) hours of orientation and annual training required by regulation. This deficient practice could likely result in harm or injury for the 65 (R #s 1-65) residents identified on the census provided by the Administrator on 10/04/22, if the DCS providing care have not received all required training and do not know how to properly care for residents. The findings are: A. Record review of DCS #6's, (Hire date 06/22/21) training file, revealed no documentation of receiving the following annual trainings: 1. Fire safety. 2. Resident rights. 3. Reporting requirements for abuse, neglect or exploitation in accordance with 7.1.13 NMAC.	{A 017}		

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{A 017}	Continued From page 2 4. Smoking policy for staff, residents and visitors. B. Record review of DCS #7's (Hire date 05/20/19), training file, revealed no documentation of receiving the following annual trainings: 1. Fire safety. 2. First Aid. 3. Safe food handling practices a. Instructions in proper storage. b. Preparation and serving of food. c. Safety in food handling d. Appropriate personal hygiene 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. C. Record review of DCS #9's (Hire date 10/06/19), training file, revealed no documentation of receiving the following annual trainings: a. Food safety. b. Reporting requirements for abuse, neglect exploitation. c. Smoking policy for staff, residents and visitors. D. On 10/06/22 at 1:30 pm, during an exit interview with the Administrator, she confirmed the training documentation findings listed above	{A 017}		

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{A 017}	Continued From page 3 for DCS #s 6, 7 and 9.	{A 017}		
{A 020}	7 NMAC 8.2.20 Admissions and Discharge ADMISSIONS AND DISCHARGE: The facility shall complete an admission agreement for each resident. The administrator of the facility or a designee responsible for admission decisions shall meet with the resident or the resident ' s surrogate decision maker prior to admission. No resident shall be admitted who is below the age of eighteen (18) or for whom the facility is unable to provide appropriate care. A. Admission agreement. The admission agreement shall include the following information: (1) the parties to the agreement; (2) the program narrative; (3) the facility's rules; (4) the cost of services and the method of payment; (5) the refund provision in case of death, transfer, voluntary or involuntary discharge; (6) information to formulate advance directives; (7) a written description of the legal rights of the residents translated into another language, if necessary; (8) the facility's staffing ratio; (9) written authorization for staff to assist with medications; (10) notification of rights and responsibilities pursuant to the Incident Reporting Intake, Processing and Training Requirements, 7.1.13 NMAC; (11) the facility ' s bed hold policy; and (12) the admission agreement may be terminated if an appropriate placement is found for the resident, under the following circumstances: (a) there shall be a fifteen (15) day written notice of termination given to the resident or his or her	{A 020}		

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{A 020}	Continued From page 4	{A 020}		

surrogate decision maker, unless the resident requests the termination;
(b) the resident has failed to pay for a stay at the facility as defined in the admission agreement;
(c) the facility ceases to operate or is no longer able to provide services to the resident;
(d) the resident ' s health has improved sufficiently and therefore no longer requires the services of the facility;
(e) termination without prior notice is permitted in emergency situations for the following reasons:
(i) the transfer or discharge is necessary for the resident's safety and welfare;
(ii) the resident's needs cannot safely be met in the facility; or
(iii) the safety and health of other residents and staff in the facility are endangered;
(13) the facility shall provide a thirty (30) day written notice to residents regarding any changes in the cost or the material services provided; a new or amended admission agreement must be executed whenever services, costs or other material terms are changed; and
(14) facilities representing their services as " specialized " must disclose evidence of staff specialty training to prospective residents.
B. Restrictions in admission. The facility shall not admit or retain individuals that require twenty-four (24) hour continuous nursing care, refer to Subsection U of 7.8.2.7 NMAC Definitions. This rule does not apply to hospice residents who have elected to receive the hospice benefit. Conditions or circumstances that usually require continuous nursing care may include but are not limited to the following:
(1) ventilator dependency;
(2) pressure sores and decubitus ulcers (stage III or IV);
(3) intravenous therapy or injections;

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{A 020}	Continued From page 5 (4) any condition requiring either physical or chemical restraints; (5) nasogastric tubes; (6) tracheostomy care; (7) residents that present an imminent physical threat or danger to self or others; (8) residents whose psychological or physical condition has declined and placement in the current facility is no longer appropriate as determined by the PCP; (9) residents with a diagnosis that requires isolation techniques; (10) residents that require the use of a Hoyer lift; and (11) ostomy (unless resident is able to provide self care). C. Exceptions to admission, readmission and retention. If a resident requires a greater degree of care than the facility would normally provide or is permitted to provide and the resident wishes to be re-admitted or remain in the facility and the facility wishes to re-admit or retain the resident. The facility shall comply with the following requirements. (1) Convene a team, comprised of: (a) the facility administrator and a facility health care professional if desired; (b) the resident or resident ' s surrogate decision maker; and (c) the hospice or home health clinician. (2) The team shall jointly determine if the resident should be admitted, readmitted or allowed to remain in the facility. Team approval shall be in writing, signed and dated by all team members and the approval shall be maintained in the resident's record and shall: (a) be based upon an individual service plan (ISP) which identifies the resident's specific needs and addresses the manner that such	{A 020}		

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{A 020}	Continued From page 6 needs will be met; (b) ensure that if the facility is licensed for more than eight (8) residents and does not have complete fire sprinkler coverage, the facility shall maintain an evacuation rating score of prompt as determined by the fire safety equivalency system (FSES); (c) evaluate and outline how meeting the specific needs of the resident will impact the staff and the other residents; and (d) include an independent advocate such as a certified ombudsman if requested by the resident, the family or the facility. (3) The team recommendation shall be maintained on site in the resident ' s file. (4) When a resident is discharged, the facility shall record where the resident was discharged to and what medications were released with the resident. D. Coordination of care. (1) Assisted living facilities shall have evidence of care coordination on an ISP for all services that are provided in the facility by an outside health care provider, such as hospice or home health providers. (2) Residents shall be given a list of providers, including hospice and home health if applicable, and have the right to choose their provider. If applicable, the referring party shall disclose any ownership interest in a recommended or listed provider. [7.8.2.20 NMAC - Rp, 7.8.2.19 NMAC & 7.8.2.20 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.20 A (5)	{A 020}		

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{A 020}	Continued From page 7 This is an uncorrected deficiency from survey dated 03/08/21. Refer to Senate Bill (SB) 0335 - 2013 AN ACT RELATING TO HEALTH CARE; REQUIRING CONTRACTS FOR ASSISTED LIVING FACILITIES TO CONTAIN A REFUND POLICY UPON TERMINATION OF A CONTRACT DUE TO THE DEATH OF THE RESIDENT; PROVIDING FOR STORAGE OF A RESIDENT'S BELONGINGS; DECLARING AN EMERGENCY. BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF NEW MEXICO: SECTION 1. A new section of the Public Health Act is enacted to read: "ASSISTED LIVING FACILITIES CONTRACTS--LIMIT ON CHARGES AFTER RESIDENT DEATH.-- A. The contract for each resident of an assisted living facility shall include a refund policy to be implemented at the time of a resident's death. The refund policy shall provide that the resident's estate or responsible party is entitled to a prorated refund based on the calculated daily rate for any unused portion of payment beyond the termination date after all charges have been paid to the licensee. For the purpose of this section, the termination date shall be the date the unit is vacated by the resident due to the resident's death and cleared of all personal belongings. B. If a resident's belongings are not removed within one week of the resident's death and the amount of belongings does not preclude renting the unit, the facility may clear the unit and charge the resident's estate for moving and storing the items at a rate equal to the actual cost	{A 020}		

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{A 020}	Continued From page 8 to the facility, not to exceed ten percent of the regular rate for the unit; provided that the responsible party for the resident is given notice at least one week before the resident's belongings are removed. If the resident's belongings are not claimed within forty-five days after notification, the facility may dispose of them. C. For the purposes of this section, "assisted living facility" means a facility required to be licensed as an assisted living facility for adults by the department of health." SECTION 2. EMERGENCY. --It is necessary for the public peace, health and safety that this act take effect immediately. Based on record review and interview, the facility failed to ensure for 9 (R #1 - 9) of 9 (R #s 1-9) residents whose Admission/Discharge Agreements were reviewed for compliance included a Refund Upon Death policy that was in compliance with NMAC 7.8.2.20 Regulations for Assisted Living Facilities and Senate Bill (SB) 0335 - 2013. This deficient practice could likely result in the residents and/or their legal representatives not being aware that the resident's estate could be at risk of not receiving monies owed and/or not being aware of additional charges that may be incurred, if the Refund Upon Death policy is not in compliance with the regulations and the Senate Bill. The findings are: A. Record review of the following residents' Admission/Discharge Agreements revealed that it did not include the Refund Upon Death policy in compliance with NMAC 7.8.2.20 Regulations for	{A 020}		

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{A 020}	Continued From page 9 Assisted Living Facilities and Senate Bill (SB) 0335 -2103: 1. R #1's agreement date 09/28/18. 2. R #2's agreement date 07/14/20. 3. R #3's agreement date 02/01/21. 4. R #4's agreement date 03/05/21. 5. R #5's agreement date 09/25/21. 6. R #6's agreement date 09/20/21. 7. R #7's agreement date 09/12/22. 8. R #8's agreement date 09/25/21. 9. R #9's agreement date 06/14/22. B. On 10/06/22 at 1:30 pm, during the exit conference, the Administrator, confirmed that R #1 - R #9's Admission/Discharge Agreements did not include the Refund Upon Death policy in compliance with NMAC 7.8.2.20 Regulations for Assisted Living Facilities and Senate Bill (SB) 0335 - 2013.	{A 020}		
{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	{A 032}		

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{A 032}	Continued From page 10 within five (5) business days and shall submit a copy of the investigation report to the licensing 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 . Based on record review and interview, the facility failed to ensure for 1 (R # 4) of 3 (R#'s 4, 5 and 6)	{A 032}	1. On 10/07/2022 the Director of Health Services reviewed the regulations referencing 7.1.13 INCIDENT REPORTING, INTAKE, PROCESSING AND TRAINING REQUIREMENTS to ensure understanding of the specific regulations and ensure corrections are made for future compliance with reporting. 2. On 10/10/2022 the Director of Health Services completed an HFL&C Incident Report regarding a fall sustained by R#4 on 10/07/2022 at 2130. On 10/17/2022 the Director of Health Services submitted a 5-Day Follow Up Report to the NM Department of Health which included the investigation report. 3. On 11/10/2022 at the Monthly All Staff Meeting, the Director of Health Services will review with employees 7.1.13 INCIDENT REPORTING, INTAKE, PROCESSING AND TRAINING REQUIREMENTS. 4. The Executive Director and the Business Office Manager will utilize the training grid to monitor and ensure all employees receive the required initial and annual training for incident reporting.	10/07/22 10/17/22 11/11/22 11/25/22

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{A 032}	Continued From page 11	{A 032}		

residents whose Internal Incident Reports were reviewed for compliance that:
1. The facility ensured that all suspected cases or known incidents of resident abuse, neglect or exploitation are reported in accordance with 7.1.13 NMAC.
2. The facility reported 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.

These deficient practices 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 #4's internal incident reports revealed:
1. Internal incident report dated 03/22/22 at 1:43 pm, states:
a. The resident had an [redacted]
b. The resident got [redacted]
c. The resident was not sent out to the Hospital and was put on two (2) hour checks.
d. The facility did not report the incident to the Licensing Authority.
2. Internal incident report dated 06/16/22 at 4:15 am, states:
a. The resident had a [redacted]
b. The resident was not sent out to the Hospital and was provided first aid.
c. The facility did not report the incident to the Licensing Authority.
3. Internal incident report dated 08/02/22 at 2:30

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{A 032}	Continued From page 12 pm states: a. The resident had an [redacted] b. The resident was not sent out to the Hospital and was provided first aid. c. The facility did not report the incident to the Licensing Authority. 4. Internal incident report dated 08/04/22 at 7:30 pm states: a. The resident had an [redacted] b. The resident was sent out to the Hospital. c. The facility did not report the incident to the licensing authority. B. On 10/06/22 at 1:30pm, during an interview with the Administrator, she confirmed that the above incidents involving R #4 were not reported to the Licensing Authority.	{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	{A 034}		

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AVAMERE AT RIO RANCHO	1000 RIVERVIEW DRIVE SE RIO RANCHO, NM 87124

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{A 034}	Continued From page 13	{A 034}		

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

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{A 034}	Continued From page 14 delivery of the medication; and (g) the balance of medication remaining. (9) Any remaining medication discontinued by a physician ' s order, or upon discharge or death of the resident shall be inventoried and moved to a separate locked storage container. Such discontinued medications shall be destroyed upon the next quarterly visit by the consulting pharmacist in accordance with 16.19.11.10 NMAC. (10) The record of medication destruction shall be signed by the administrator or designee and the pharmacist and shall be kept on file at the facility. B. Consulting pharmacist. The facility shall maintain records demonstrating that the consulting pharmacist provides the following oversight and guidance. (1) Reviews the medication regimen as needed, but at least quarterly/every three (3) months, to determine that all medications and records are accurate and current. All irregularities shall be reported to the administrator of the facility and these irregularities shall be resolved by the administrator within seventy-two (72) hours. (2) A system of records of receipt and disposition of all drugs in sufficient detail to enable an accurate reconciliation. (3) Consultation shall be provided on all aspects of pharmacy services in the facility, including reference information regarding side effects and, when needed, physician consultation in cases involving the use of psychotropic medications. (4) The consulting pharmacist will be responsible for assuring that the facility meets all requirements for storage, labeling, destruction and documentation of medications as required by the state board of pharmacy, 16.19.11.10 NMAC and 7.8.2 NMAC.	{A 034}		

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{A 034}	Continued From page 15 [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 (5) This is an uncorrected deficiency from survey dated 10/13/21 Based on record review, observation, and interview the facility failed to ensure for 1 (R #6) of 1 (R #6) who self administers [redacted] own medications, that the medications were stored in a secured, locked compartment in the resident's room. This deficient practices could likely result in the residents being at risk of harm, injury, or death if: 1. The unsecured self-administered medications stored in the resident's room were readily accessible to other residents, staff, or visitors. 2. Were lost or stolen. 3. The resident was not storing his medication as appropriately. 4. The resident was not able to locate and take his medications as prescribed. The findings are: A. On 10/06/22 at 9:57 am, during observation of R #6's room, the following medications were observed unsecured in the resident's room: [redacted] located on the	{A 034}	1. R#6 has been hospitalized since [redacted]/22 and [redacted] apartment has been secured. Upon [redacted] return, the Director of Health Services will meet with R#6 to review the requirement of placing all medications in a locked drawer supplied by the facility for this purpose. 2. R#6 will have [redacted] overflow stock of [redacted] stored in the locked refrigerator in the Medication Room of assisted living. 3. Within 30 days an audit of all resident apartments that self-administer their own medications will be conducted and assistance provided to secure all medications in the locked drawer provided by the facility. 4. The Director of Health Services will be respons ble for ongoing education to residents who self-administer their own medications quarterly during the individual residents quarterly evaluation for self-administration of medications.	11/25/22 or upon return to facility. 10/25/22 11/25/22 10/26/22

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{A 034}	Continued From page 16 resident's desk. [redacted] located on the resident's desk. B. On 10/06/22 at 11:48am, during an interview, the Administrator confirmed that R #6's medications listed above were not being stored in a locked or secured place in [redacted]	{A 034}		
{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	{A 066}		

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{A 066}	Continued From page 17 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 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 D (4) This is an uncorrected deficiency for survey dated 10/13/21. Based on record review and interview, the facility failed to ensure a record of the conducted fire drills were maintained on file in the facility documenting: 1. The time of the drill 2. The number of personnel participating in the drill 3. Any problem(s) noted during the drill 4. The evacuation time in total minutes. This deficient practice could likely result in the residents listed on the resident census provided by the Director of Health on 10/04/22, to be at risk of harm, injury, or death if a fire or other emergency were to occur, if:	{A 066}	1. On 10/04/22 the Avamere Regional Director of Maintenance was at the facility for his quarterly site visit and training with the facility Maintenance Director. The Regional printed the NM Regulations for Assisted Living and Memory Care and went over training specific to requirements for 7 NMAC 8.2.66 Staff and Resident Fire Safety Training. 2. On 10/25/22 the Director of Health Services confirmed with the facility Maintenance Director that fire drills are scheduled in the TELS system to populate with a date and time the monthly fire drill is due. Facility Maintenance Director confirmed that he has a binder in which to file all fire drills and evacuation drills using the correct form that indicates the time of the fire drill, the number of employees participating in the drill, the number of residents participating in the drill, any problems that were noted during the drill and the total evacuation time in minutes. 3. The Executive Director will be responsible for monitoring and ensuring compliance with the requirements of 7 NMAC 8.2.66 during monthly CQI Meetings.	

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{A 066}	Continued From page 18 1. Residents have not received training on what actions to take in case of a fire. 2. Residents have not received evacuation training, practiced using the evacuation routes/exits, and do not know how to safely evacuate the facility. 3. The staff are not aware of resident issues that occurred during the evacuation or the time it takes for the staff to safely evacuate the residents from the facility. The findings are: A. Record review of the facilities monthly fire drill records dated 03/31/22 through 09/30/22 revealed no documentation of: 1. The time the drills were conducted. 2. The number of personnel participating in the drills. 3. Any problem(s) noted during the drills. 4. The evacuation time in total minutes it takes to evacuate the residents. B. On 10/05/22 at 10:23 am, during an interview with the Director of Health, she confirmed that there was no documentation for the above findings and is unknown if documentation was being completed.	{A 066}		