

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 5280	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 04/14/2022
NAME OF PROVIDER OR SUPPLIER CASA DEL VALLE I			STREET ADDRESS, CITY, STATE, ZIP CODE 2111 RAVEN LANE SW ALBUQUERQUE, NM 87105		
(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 04/14/22 for the state requirements of 7 NMAC 8.2, Regulations for Assisted Living Facilities. Complaint Intake #46301 was unsubstantiated with no deficiencies cited. Complaint Intake #49584 was unsubstantiated with no deficiencies cited.	A 000			
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,	A 020			

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATE FORM

6899

SSDZ11

TITLE

(X6) DATE

If continuation sheet 1 of 28

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A 020	Continued From page 1 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 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	A 020			

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A 020	Continued From page 2 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; (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	A 020			

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A 020	Continued From page 3 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 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.	A 020			

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A 020	Continued From page 4 [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) 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	A 020			

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A 020	Continued From page 5 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 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/request and interview, the facility failed to ensure for 3 (R #'s 1-3) of 3 (R #'s 1-3) residents whose Admission/Discharge Agreements were reviewed for compliance included the Refund Upon Death policy that was in compliance with Senate Bill (SB) 0335 - 2013 and 7 NMAC 8.2.20 and were readily available for review. This deficient practice could likely result in the resident's estate/legal representatives being at risk of suffering financial hardship by not receiving monies owed upon the resident's death or incurring unknown charges for storage of their belongings. The findings are: A. Record request for R #1's (Admitted on	A 020	① Facility will implement a Policy/Documentation of Agreement between Facility and Resident Regarding Refunds Policy due to death or discharge, or Emergency. ② Facility will implement said Agreement upon each admission. ③ Facility will have said Agreement in place for each resident by 6/15/22.	

④ Facility will be in compliance with Senate Bill 0335 and Assisted Living Regulations.

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A 020	Continued From page 6 [REDACTED] 22) Admission and Discharge revealed no documentation of an Admission/Discharge Agreement was readily available for review. B. Record review of R #2's Admission/Discharge Agreement dated [REDACTED] 15, revealed it did not include a refund upon death policy in compliance with Senate Bill (SB) 0335 - 2013 and 7 NMAC 8.2.20. C. Record review of R #3's Admission/Discharge Agreement dated [REDACTED] 15, revealed it did not include a refund upon death policy in compliance with Senate Bill (SB) 0335 - 2013 and 7 NMAC 8.2.20. D. On 04/14/22 at 11:27 am, during an interview with House Manager, she confirmed that: 1. There was not a completed Admission/Discharge agreement readily available to review for R #1. 2. The Admission/Discharge Agreements for R #s 2 & 3 did not include the Refund Upon Death policy in compliance with SB 0335 -2013 and 7 NMAC 8.2.20.	A 020			
A 022	7 NMAC 8.2.22 Facility Reports, Records, Rules, Policies FACILITY REPORTS, RECORDS, RULES, POLICIES AND PROCEDURES: A. Reports and records. Each facility shall keep the following reports, records, policies and procedures on file at the facility and make them available for review upon request by the licensing authority, residents, potential residents or their surrogate decision makers: (1) fire inspection report; (2) zoning approval;	A 022			

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A 022	Continued From page 7 (3) building official approval (certificate of occupancy); (4) a copy of the approved building plans; (5) a copy of the most recent survey conducted by the licensing authority, to include adverse actions or appeals and complaints; (6) for facilities with food establishments/kitchens that require a permit from the local health authority that has jurisdiction, a copy of the current inspection report in accordance with the applicable, municipal, or federal laws and regulations and pursuant to Subsection B of 7.6.2.8 NMAC, regarding kitchen and food management; if a facility is considered a licensed private home and not required to meet specific requirements by the local health authority, a copy of that determination must also be maintained; (7) where necessary, a copy of the liquid waste disposal and treatment system permit from the local health authority that has jurisdiction; (8) thirty (30) days of menus as planned, including snacks and thirty (30) days of menus as served, including snacks; (9) record of monthly fire drills conducted at the facility and the fire safety evaluation system (FSSES) rating, if applicable; (10) written emergency plans, policies and procedures for medical emergencies, power failure, fire or natural disaster; plans shall include evacuation, persons to be notified, emergency equipment, evacuation routes, refuge areas and the responsibilities of personnel during emergencies; plans shall also included a list of transportation resources that are immediately available to transport the residents to another location in an emergency; the emergency preparedness plan shall address two types of emergencies: (a) an emergency that affects just the facility; and	A 022			

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A 022	Continued From page 8 (b) a region/area wide emergency; (11) a copy of this rule, Requirements for Assisted Living Facilities for Adults, 7.8.2 NMAC; (12) for facilities with two or more residents (that are not related to the owner), a valid custodial drug permit issued by the NM board of pharmacy, that supervise administration and self-administration of medications or safeguards with regard to medications for the residents; and (13) vaccination records for pets in the facility. B. Reports and records. Each facility shall keep the following reports, records, policies and procedures on file at the facility and make them available for review upon request by the licensing authority: (1) a copy of the facility license; (2) employee personnel records, including an application for employment, training records and personnel actions: (a) caregiver criminal history screening documentation pursuant to 7.1.9 NMAC; (b) employee abuse registry documentation pursuant to 7.1.12 NMAC; and (3) a copy of all waivers or variances granted by the licensing authority. C. Rules. Prior to admission to a facility a prospective resident or his or her representative shall be given a copy of the facility rules. Each facility shall have written rules pertaining to resident ' s rights and shall include the following: (1) resident use of tobacco and alcohol; (2) resident use of facility telephone or personal cell phone; (3) resident use of television, radio, stereo and cd; (4) the use and safekeeping of residents ' personal property; (5) meal availability and times; (6) resident use of common areas;	A 022			

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A 022	Continued From page 9 (7) accommodation of resident ' s pets; and (8) resident use of electric blankets and appliances. D. Policies and procedures. All facilities shall have written policies and procedures covering the following areas: (1) actions to be taken in case of accidents or emergencies; (2) policy and procedure for updating and consolidating the residents current physician or PCP orders, treatments and diet plans every six (6) months or when a significant change occurs, such as a hospital admission; (3) policy for medication errors; (4) method of staying informed when residents are away from the facility (e.g., sign-out sheets or other record indicating where the resident will be, cell phone contact, etc.); (5) the handling of resident's funds, if the facility provides such services; (6) reporting of incidents, including abuse, neglect and misappropriation of property, injuries of unknown cause, environmental hazards and law enforcement interventions in accordance with 7.1.13 NMAC; (7) reporting and investigating internal complaints; (8) reporting and investigating complaints to the incident management bureau; (9) staff and resident fire and safety training; (10) smoking policy for staff, residents and visitors; (11) the facility's bed hold policy; (12) admission agreement; (13) admission records; (14) resident records including maintenance and record retention if the facility closes; (15) program narrative; (16) resident's rights with regard to making health	A 022			

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A 022	Continued From page 10 care decisions and the formulation of advance directives; (17) personnel policies; (18) identifying and safeguarding resident possessions; (19) securing medical assistance if a resident's own physician is not available; (20) staff training appropriate to staff responsibilities; (21) staff training for employees who provide assistance to residents with boarding or alighting from motor vehicles and safe operation of motor vehicles to transport residents; (22) witnessed destruction of unused, outdated or recalled medication by the facility administrator with the consulting pharmacist present; and (23) mealtimes, daily snacks, menus, special diets, resident's personal preference for eating alone or in the dining room setting. [7.8.2.22 NMAC - Rp, 7.8.2.23 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.22 A (10) (b) Based on record review and interview, the facility failed to ensure that there was a written emergency evacuation plan for community-wide disasters with shelter arrangements. This deficient practice could likely negatively affect the health and safety of the 7 (R #s 1-7) residents listed on the resident census, provided by the Administrator on 04/13/22, if there is no emergency evacuation plan for community-wide disasters. The findings are:	A 022	① Facility will Implement a Policy/Documentation regarding Emergency Evacuation Plan for Community wide disasters for each resident. ② Facility will complete a Policy/Documentation regarding Emergency Evacuation for each resident upon Admission. ③ Facility will Complete said Policy/Documentation by 6/14/22.		

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A 022	Continued From page 11 A. Record review of the facility's policies and procedures, revealed that there was no written emergency disaster plan in the event of a community-wide or regional disaster. B. On 04/14/22 at 11:20 am, during an interview with the House Manager, she confirmed that there was no written emergency disaster plan in the event of a community-wide or regional disaster.	A 022		
A 023	7 NMAC 8.2.23 Pets PETS: Pets are permitted in a licensed facility, in accordance with the facility's rules. A. Prohibited areas. Animals are not permitted in food processing, preparation, storage, display and serving areas, or in equipment or utensil washing areas. Guide dogs for the blind and deaf and service animals for the handicapped shall be permitted in dining areas pursuant to Subsection K of 7.6.2.9 NMAC. B. Vaccination. Pets shall be vaccinated in accordance with all state and local requirements and records of such vaccination shall be kept on file in the facility. [7.8.2.23 NMAC - Rp, 7.8.2.24 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.23 B Based on record review and interview, the facility failed to ensure that pets (dogs) living in the facility had current vaccination records on file at the facility.	A 023	① Facility will ensure that each pet has current vaccinations recorded on hand and on record at Facility. ② Facility will maintain current pet vaccinations at all times. ③ Pet in question has current vaccination as of 5/1/2022.	

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A 023	Continued From page 12 This deficient practice has the potential for all 7 (R #s 1-7) residents listed on the census provided by the Administrator on 04/13/22 to be a risk of harm or illness, if the residents are bitten or contract communicable diseases from the animal that does not have current vaccinations. The findings are: A. Record review of vaccinations for two pets living in the facility, revealed that 1 of the 2 pets residing in the facility vaccines had expired on 06/19/21. B. On 04/14/2022 at 10:28 am, during an interview with the House Manager, she confirmed that the vaccination records for 1 of the 2 pets living in the facility were not up to date.	A 023		
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,	A 025		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 025	Continued From page 13 behaviors or status: (1) activities of daily living; (2) cognitive abilities; reasoning and perception; the ability to articulate thoughts, memory function or impairment, etc; (3) communication and hearing; ability to communicate needs and understand instructions, etc; (4) vision; (5) physical functioning and skeletal problems; (6) incontinence of bowel/bladder; (7) psychosocial well-being; (8) mood and behavior; (9) activity interests; (10) diagnoses; (11) health conditions; (12) nutritional status; (13) oral or dental status; (14) skin conditions; (15) medication use and level of assistance needed with medications; (16) special treatments and procedures or special 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]	A 025		

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NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

CASA DEL VALLE I

2111 RAVEN LANE SW
ALBUQUERQUE, NM 87105

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A 025	Continued From page 14 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 were completed within 15 days prior to admission and updated at a minimum of every 6 months. This deficient practice is likely to result in residents not receiving appropriate care/services upon admission 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 resident file revealed that there was no documentation that an evaluation was completed within 15 days prior to admission on 01/21/22. B. Record review of R #2's (date of admission [REDACTED] 07) resident evaluations dated 01/28/21 and 02/18/22, revealed that the evaluation had not been updated at a minimum of every 6 months. C. Record review of R #3's (date of admission [REDACTED] 14) resident evaluations dated 01/28/21 and 02/18/22, revealed that an evaluation had not been updated at a minimum of every 6 months. D. On 04/14/22 at 11:00 am, during an interview with the House Manager, she confirmed that:	A 025	① Facility will ensure that each Resident has a complete evaluation with 15 day prior to admission and every 6 months or upon significant change in health status occurs. ② Facility will monitor Admission paperwork to ensure compliance to evaluation requirement and review clients chart every 6 months or if significant change in health status occurs to ensure complete evaluation is completed. ③ Compliance to Regulation will take place immediately and upon admission of any new residents.	

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A 025	Continued From page 15 1. R #1's evaluation was not completed within 15 days prior to admission on [REDACTED] 22. 2. R #s 2 & 3 evaluations has not been updated at a minimum of every 6 months.	A 025		
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. (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	A 034		

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A 034	Continued From page 16 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. (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	A 034			

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A 034	Continued From page 17 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] This REQUIREMENT is not met as evidenced by: 7.8.2.34 A (3) Based on observation and interview the facility failed to ensure that the residents medications were stored securely, in a separate, locked refrigerator, and not accessible to other residents/staff/visitors. This deficient practice could likely result in harm to the 7 (R #s 1-7) residents listed on the resident	A 034	① Facility will install a locked Refrigerator for storage of Residents medications locked and away from others. ② Facility will maintain separate medication Refrigerator for medications at all times. ③ Facility will have separate/locked Refrigerator for client's medication by 5/14/22.	

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A 034	Continued From page 18 census provided by the Manager on 04/12/22 , if their medications were easily accessible to residents, staff or visitors. The findings are: A. On 04/13/22 at 2:48 pm, during observation of refrigerator located in the Meeting Room, R #4's [REDACTED] medication was observed to be stored near food, in an unlocked, family refrigerator. B. On 04/13/22 at 2:50 pm, during an interview with DCS #2 and Administrator, they both acknowledged and confirmed that the medication prescribed to R #4, was stored in a non-secured refrigerator and they were accessible to residents/staff/visitors.	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	A 035			

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A 035	Continued From page 19 consent, the surrogate decision maker named in accordance with New Mexico law may give written consent for assistance with self-administration of medications. All staff that assist with self-administration of medications shall have successfully completed a state approved assistance with self-administration of medication training program or be licensed or certified by the state board of nursing. C. PRN (pro re nada) medication. (1) Physician or physician extender ' s orders for PRN medications shall clearly indicate the circumstances in which they are to be used, the number of doses that may be given in a 24-hour period and indicate under what circumstances the primary care practitioner (PCP) is to be notified. (2) The utilization of PRN medications shall be reviewed routinely. Frequent or escalating use of 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	A 035			

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A 035	Continued From page 20 over-the-counter medication that is assisted with self-administration by qualified staff or administered to the resident by licensed or certified staff. The information in the MAR shall include: (1) the resident's name; (2) any known allergies to medication that the resident has; (3) the name of the resident's PCP or the prescriber of the medication; (4) the diagnosis or reason for the medication; (5) the name of the medication, including the drug product brand name and the generic name; (6) notation if the medication is a schedule II-IV drug; (7) the dosage of the medication; (8) the strength of the medication; (9) the frequency or how often the medication is 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	A 035		

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A 035	Continued From page 21 (20) any medication error. H. No medication shall be stopped or started without specific orders from the primary care physician. I. If a resident refuses to take a prescribed medication, it shall be documented and the facility shall report it to the prescriber. J. A suspected adverse reaction to a medication shall be documented on the MAR and reported immediately to the PCP and the resident's surrogate decision maker. If applicable, emergency medical treatment shall be arranged. Documentation of the event shall be kept in the resident's record. K. Prescription medication, other than blister packs and unit dose containers, shall be kept in the original container with a pharmacy label that includes the following: (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]	A 035		

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A 035	Continued From page 22 This REQUIREMENT is not met as evidenced by: 7.8.2.35 G (2-5) (12) 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 Medication Administration Records (MARs) were reviewed for compliance that all medications on the MAR included: 1. Any known allergies to medication the resident has. 2. Name of the resident's Primary Care Physician (PCP). 3. Diagnosis or reason for the medication. 4. Both brand/generic names. 5. Initial date the medication was started. This deficient practice could likely result in the residents being at risk of harm if Direct Care Staff (DCS) do not: 1. Know what allergies the resident has. 2. Know who the resident's PCP is. 3. The reason for the medication. 4. Recognize the name of the medication. 5. Know the date the medication was started. which may result in medication errors occurring due to vital information missing on the MAR. The findings are: A. Record review of R #1's MAR from 04/01/22 through 04/14/22, revealed that it did not include all of the following vital information: 1. Name of the residents Primary Care Physician (PCP) 2. Diagnosis or reason for the medication 3. Both brand/generic names 4. Initial date the medication was started,	A 035	① Facility will request and try to have client's provider have correct MAR's to include Name, Diagnosis, Allergies, Name and initial date on each MAR. ② Facility will inspect + monitor ea. Client's MAR on a monthly basis to ensure compliance to DSH Regulations. ③ Facility will attempt to have ea. Client's PCP provide current and accurate MAR, by DSH Regs, by 5/14/22.	

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A 035	Continued From page 23 B. Record review of R #2's MAR from 04/01/22 through 04/14/22, revealed that it did not include all of the following vital information: 1. Any known allergies to medication the resident has. 2. Name of the residents Primary Care Physician (PCP). 3. Diagnosis or reason for the medication. 4. Both brand/generic names. 5. Initial date the medication was started. C. Record review of R #3's MAR from 04/01/22 through 04/14/22, revealed that all of the medications on the MAR did not include: 1. Diagnosis or reason for the medication 2. Both brand/generic names 3. Initial date the medication was started D. On 04/14/22 at 11:40 am, during an interview with the House Manager, she confirmed that all reviewed MAR's for residents R #'s 1-3 lacked the required vital information listed above.	A 035			
A 048	7 NMAC 8.2.48 Electrical System ELECTRICAL SYSTEM: A. All fuse and breaker boxes shall be labeled to indicate the area of the facility to which each fuse or circuit breaker provides service. B. All staff personnel of the facility shall know the location of the electrical disconnect switch and how to operate it in case of emergency. C. Electrical cords and appliances shall be U/L approved. (1) Electrical cords shall be replaced as soon as they show wear. (2) Extension cords shall not be used. The use of a multi-socket united laboratories approved (U/L	A 048			

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A 048	Continued From page 24 APPROVED) surge protector with integrated circuit breaker no greater than six (6) feet in length is permitted for the intended purpose and not as an extension cord. [7.8.2.48 NMAC - Rp, 7.8.2.49 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.48 A Based on observation and interview the facility failed to ensure that all fuse and breaker boxes were labeled to indicate the area of the facility to which each fuse or circuit breaker provides service. This deficient practice could likely negatively affect the 7 (R #s 1-7) residents listed on the resident census provided by the Administrator on 04/13/22 to be at risk of harm if there is a power failure and the Direct Care Staff (DCS) do not know which breaker restores power to areas of the facility. The findings are: A. Observation of the facility's outer West breaker box revealed that the switches were not labeled. B. On 04/13/22 at 3:00 pm during an interview with the Administrator, he confirmed that the outer West breaker box was not labeled.	A 048	① Facility will and has corrected the non-labeling of electrical breaker boxes in Facility's main breaker box. ② Facility will maintain proper labeling of electrical boxes. ③ Facility has correct unlabeled circuit boxes as of 4/15/2022.		
A 064	7 NMAC 8.2.64 Fire Safety Equivalency System Rating FIRE SAFETY EQUIVALENCY SYSTEM RATING: In facilities without a sprinkler system;	A 064			

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A 064	Continued From page 25 the fire safety equivalency system shall be conducted at least annually. The facility shall maintain an evacuation rating score of prompt when a fire safety equivalency system is required. [7.8.2.64 NMAC - Rp, 7.8.2.19 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.64 Based on record request and interview, the facility failed to ensure that the Fire Safety Equivalency System Rating (FSES) score forms were completed at least annually and available for review. This deficient practice could likely to result in all 7 (R #s 1-7) residents identified on the census list provided by the Administrator on 04/13/22, to be at risk of harm, injury, or death if there are not enough staff on duty to safely evacuate the residents if a fire were to occur. The findings are: A. Record request for the facility's FSES evacuation rating score forms for the 7 residents revealed that there was no documentation of any FSES available to review. B. On 04/13/22 at 3:00 pm, during an interview with the Administrator, he confirmed that there was no documentation of FSES rating forms available for review.	A 064	① Facility will maintain a current FSES score for all residents, in compliance to DCH Regulations. ② Facility will on a monthly basis conduct a current FSES Scoring Sheet for all residents to ensure compliance to DCH Regulations. ③ Facility will have and maintain FSES Score Forms for all residents by 5/1/22.	
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	A 065		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 5280	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 04/14/2022
NAME OF PROVIDER OR SUPPLIER CASA DEL VALLE I		STREET ADDRESS, CITY, STATE, ZIP CODE 2111 RAVEN LANE SW ALBUQUERQUE, NM 87105		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 065	Continued From page 26 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 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 Based on record review and interview, the facility failed to ensure that fire drills were conducted monthly on each eight (8) hour shift (day, evening, night) per quarter. This deficient practice could likely result in the 7 (R #s 1-7) residents identified on the census list, provided by the Administrator on 04/13/22, to be at risk of harm, injury, or death if Direct Care Staff (DCS) do not know how to safely evacuate the residents from the building if a fire were to occur. The findings are: A. Record review of the facility's fire drill records dated 01/03/22 and 03/04/22 revealed that there was no fire drill conducted for the month of	A 065	① Facility will conduct and maintain monthly fire drill on a monthly basis, on each 8 hr shift per quarter. ② Facility will conduct monthly fire drill. ③ Facility will have and maintain monthly fire drills by 5/14/22.	

Division of Health Improvement

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A 065	Continued From page 27 February. There was no documentation showing that the facility conducted any monthly fire drills prior to 01/03/22. B. On 04/14/22 at 9:50 am, during an interview with the House Manager, she confirmed that the facility had not conducted any fire drills in February and none prior to 01/03/22.	A 065			



MICHELLE LUJAN GRISHAM
Governor

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

April 28, 2022

Gary Sandoval, Administrator
Casa Del Valle I
2111 Raven Lane SW
Albuquerque, NM 87105

License # 5280

IMPORTANT NOTICE - PLEASE READ IMMEDIATELY

Dear Mr. Sandoval:

On **April 14, 2022**, a Complaint Survey was conducted at Casa Del Valle I 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

DIVISION OF HEALTH IMPROVEMENT

2040 South Pacheco Street, 2nd Floor, Suite 202 • Santa Fe, New Mexico • 87505
(505) 476-9025 • FAX: (505) 476-8980 • www.dhi.health.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.

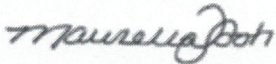
Informal Dispute Review (IDR)

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: April 14, 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.

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