Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2219	A. BUILDING: _____ B. WING _____	C 10/21/2022

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

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A 000	Initial Comments The following (8) deficiencies were cited during a Full-Onsite/Complaint survey completed on 10/21/22, for the state requirements of 7 NMAC 8.2, Regulations for Assisted Living for Adults. Complaint Intake NM58582 was unsubstantiated with no deficiencies cited.	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;	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 audit will be conducted, a new tracking log will be created (a spreadsheet with all new hires dat ! and checklist of completion). The administrator or designee with monitor. Facility started audit on Oct 10, 2022. An audit will be conducted quarterly.	

Division of Health Improvement
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE 11/17/22

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A 017	Continued From page 1 (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 the required: 1. 16 hours supervised training prior to providing unsupervised resident care. 2. 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 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 #1's employee file (hire date 04/04/22), revealed no documentation of the following training requirements with proof of competency: 1. Sixteen (16) hours of supervised training prior	A 017		

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A 017	Continued From page 2 to providing unsupervised care for residents. 2. Twelve (12) hours of training at orientation, with proof of competency. B. Record review of DCS #2's employee file (hire date 03/15/22), 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. 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 1 & 2 employee files did not contain documentation of the DCS completing the required training that included: 1. Sixteen (16) hours of supervised training prior to providing unsupervised care for residents. 2. Twelve (12) hours of training at orientation with proof of competency.	A 017		
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.	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 3 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 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	A 025		

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A 025	Continued From page 4 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: 7.8.25 A Based on record review and interview the facility failed to ensure for 1 (R #1) of 4 (R #s 1-4) residents whose Evaluations were reviewed for compliance that the evaluation was 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 service required by resident can be met by the facility. This deficient practice could likely result in residents not receiving appropriate care/services upon admission, incase the resident's condition changed, and 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 (Admission Date [redacted]22), revealed an initial Evaluation dated [redacted]22, Twenty four (24 days) earlier; not within 15 days required by regulation. Conditions of the resident could have changed in the 24 days. B. On 09/28/22 at 8:45 am, during an interview with Licensed Practical Nurse (LPN)) #1, she confirmed that the initial resident evaluation for R #1 was done 24 days prior to admission date.	A 025		

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A 026	7 NMAC 8.2.26 Individual Service Plan INDIVIDUAL SERVICE PLAN (ISP): An ISP shall be developed and implemented within ten (10) calendar days of admission for each resident residing in the facility._ A. The ISP shall address those areas of need as identified in the resident evaluation and through staff observation. (1) The ISP shall detail the services that are provided by the facility as well as the services to be provided by other agencies. (2) The resident evaluation and the ISP shall be reviewed and if needed revised by a licensed practical nurse, registered nurse or a physician extender. (3) The ISP shall be reviewed and or revised at a minimum of every six (6) months or when there is a significant change in the resident ' s health status. B. The ISP shall include the following: (1) a description of identified needs as noted in the resident evaluation; (2) a written description of all services to be provided; (3) who will provide the services; (4) when or how often the services will be provided; (5) how the services will be provided; (6) where the services will be provided; (7) expected goals and outcomes of the services; (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.	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 6 [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 Based on record review and interview the facility failed to ensure for 1 (R #1) of 4 (R #'s 1 - 4) residents whose records were reviewed for compliance that their Individual Service Plans (ISPs) (Care Plan) was developed and implemented within (10) calendar days of admission. This deficient practice could likely negatively affect the health, safety, and welfare of residents, if their ISP's were not being created, reviewed, and revised as required to ensure the DCS are providing the correct care and services to the residents. The findings are: A. Record review of R #1's ISP dated 04/12/22, revealed no documented evidence that an initial ISP (Care Plan) was developed and implemented within (10) calendar days of admission on [redacted]22. B. On 09/28/22 at 8:45 am, during an interview with Licensed Practical Nurse (LPN) #1, she confirmed that R #1's initial ISP (Care Plan) was not developed and implemented within (10) calendar days of admission date.	A 026		

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A 032	Continued From page 7	A 032		
A 032	7 NMAC 8.2.32 Reporting of Incidents REPORTING OF INCIDENTS: A. The facility shall insure that all suspected cases or known incidents of resident abuse, neglect or exploitation are reported in accordance with 7.1.13 NMAC. (1) The facility shall also report any incident or unusual occurrence which has or could threaten the health, safety, or welfare of the residents and staff to the licensing authority complaint hotline within twenty-four (24) hours or by the next business day, if it is a weekend or a holiday. (2) The facility shall not delay a report to the complaint hotline while an internal investigation is conducted. B. The facility is responsible for conducting and documenting the investigation of all incidents within five (5) business days and shall submit a copy of the investigation report to the licensing 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: Surveyor: Karaara, Millie	A 032	Facility will report all suspected and known incidents of resident abuse, neglect, or exploitation in accordance to 7.1.13 NMAC within 24 hours. A report will be send in to the State. Facility will conduct an internal investigation within 5 business days and will submit proper documentation per regulations. Also we will reach out for a re-training review by NMDOH, on incident reporting. Facility to be in full compliance by Nov 1, 2022. Campus Nurse or designee	

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A 032	Continued From page 8 REPORTING OF INCIDENTS 7.8.2.32 A. (1-2) B. (1- 3) 7.1.13 INCIDENT REPORTING, INTAKE, PROCESSING AND TRAINING REQUIREMENTS Refer to 7.1.13.7 W, 8 B. (2), 10 C. W. "Reportable incident" means possible abuse, neglect, exploitation, injuries of unknown origin and other events including but not limited to falls which cause injury, unexpected death, elopement, medication error which causes or is likely to cause harm, failure to follow a doctor's order or an ISP, or any other incident which may evidence abuse, neglect, or exploitation. B. (2) Division incident report form and notification by licensed health care facilities: The licensed health care facility shall report incidents utilizing the division's incident report form consistent with the requirements of the division's incident management system guide and CMS regulations as applicable. The licensed health care facility shall ensure that all incident report forms alleging abuse, neglect, exploitation, injuries of unknown origin or other reportable incidents are submitted by a reporter with direct knowledge of an incident, are completed on the bureau's incident report form and received by the division within twenty-four (24) hours of an incident or allegation of an incident or the next business day if the incident occurs on a weekend or a holiday. The licensed health care facility shall ensure that the reporter with the most direct knowledge of the incident assists with the preparation of the incident report form. C. All licensed health care facilities shall conduct	A 032		

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A 032	Continued From page 9 a complete investigation and report the actions taken and conclusions reached by the facility within five (5) days of discovery of the incident. [7.1.13.10 NMAC - Rp, 7.1.13.11 NMAC, 7/1/14] Based on record review and interview, the facility failed to ensure for 1 (R #1) of 3 (R #s 1-3) residents whose Internal Incident Reports (IRs) were reviewed for compliance: 1. Reported to the Licensing Authority within 24 hours or the next business day if it is a weekend or a holiday. 2. The facility conducted and documented the investigation of all reportable incidents within five (5) business days and submit a copy of the investigation report to the Licensing Authority. These deficient practices could potentially result in the residents listed on the census provided by the facility's Administrator on 09/27/22, to be at risk of harm, injury, and/or death, due to the facility failing to report any "Reportable incident" to the Licensing Authority for oversight. The findings are: A. Record review of R #1's facility's Internal Report IRs for 2022 revealed the following: 1. IR dated 03/02/22 at 1:24 pm. Resident (R #5) seen by staff outside on top of R #1. R #5 [redacted] R #1 who was crying. When caregiver went to separate the two, R #5 tried to touch DCS's chest. Licensed Practical Nurse (LPN) helped DCS get R #1 off the ground into a wheelchair and was assisted into bed. R #5 stated [redacted] was trying to inspire R #1 to wake up. R #5's family request that resident be moved to a different unit. There was no documentation that R #1 needed medical care or that the police were involved.	A 032		

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A 032	Continued From page 10 2. IR dated 03/03/22 at 8:52 pm, resident sitting at dining chair, next moment the nurse turns around, resident is laying on the floor. Nurse got help from caregiver to get [redacted] off the floor. Resident was not talking and acting in odd behavior for a few days now. Resident acting violently, refusing care, and throwing objects to the floor, spitting at staff. The report stated that R #1's family was notified and that the residents has had this type of behaviors in the past. There was no documentation that resident suffered any injuries or that resident had been evaluated after the incident. 3. IR dated 03/27/22 at 4:05 am. resident was heard yelling and screaming. Resident was hitting the wall, threw [redacted] on the floor saying: [redacted] Resident went to dining area and started threatening another resident stating [redacted] Resident preceded to screaming so loudly [redacted] woke up two other residents and was disturbing their peace. Resident stated [redacted] Resident was sent to the hospital emergency room. Resident had [redacted] from hitting the wall. There was no documentation of what was done at the hospital but on R #1's evaluation dated 04/12/22, the resident was being monitored by staff for [redacted] 4. IR dated 08/27/22 of an unwitnessed fall at 1:00 am, the resident heard crying in [redacted] DCS found [redacted] between the bed and night stand, resident fell trying to get to restroom, and hurt [redacted] There was not documentation that the resident received any medical care after the incident. 5. IR dated 09/23/22 of an unwitnessed fall at 7:25 am in the bathroom. Resident felt dizzy while	A 032		

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A 032	Continued From page 11 on the toilet and fell, said [redacted] felt pain at the [redacted] There was no documentation to show that the resident received any medical care though the physician and family were informed. 6. IR dated 09/23/22 of an unwitnessed fall at 11:29 am. Resident was reaching to open [redacted] There was no documentation to show that the resident received any medical care though the physician and family were informed. B. Record review of the facility Unit C's Internal Incident Reports dated 01/01/22 through 09/30/22, revealed there was no documentary evidence that the facility reported the above incidents for R #1 to the Licensing Authority within 24 hours or the next business day if a holiday or weekend and that an internal investigation was conducted within 5 business days and submitted a copy of the investigation report to the Licensing Authority. C. On 10/24/22 at 12:28 pm, an email was sent to the Administrator to confirm that the findings above should have been reported to the Licensing Authority within 24 hours, or the next business day and the facility did not conduct an investigation on the above incidents within 5 business days. D. On 10/26/22 at 11:37 am (via email), the Administrator confirmed the above findings.	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	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 unavailability, 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. (continue to next pg)	

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A 034	Continued From page 12 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 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	A 034	On Oct 14, a new audit tracking log was created. Random inspections and audits will be conducted weekly. Administrator or designee will monitor.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2219	A. BUILDING: _____ B. WING _____	C 10/21/2022

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

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A 034	Continued From page 13 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 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	A 034		

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	2219	A. BUILDING: _____ B. WING _____	C 10/21/2022

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

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A 034	Continued From page 14 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 (4) Based on observation, and interview the facility failed to ensure for 3 (R #s 1,3, & 4) of 4 (R #s 1-4) residents that: 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 labeled with the resident's name. The findings are:	A 034		

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	2219	A. BUILDING: _____ B. WING _____	C 10/21/2022

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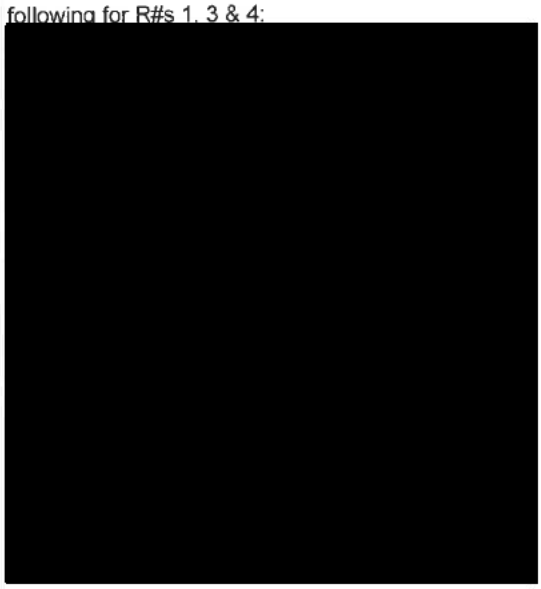
A 034	Continued From page 15 A. On 09/29/22 at 2:40 pm, observation of the medication cart with DCS #3, revealed the following for R#s 1, 3 & 4:  B. On 09/29/22 at 3:15 pm, during an interview with DCS #3, she confirmed the findings above. C. On 09/29/22 at 4:30 pm, during an interview with Licensed Practical Nurse (LPN) #1, she confirmed the findings above.	A 034		
A 036	7 NMAC 8.2.36 Nutrition NUTRITION: The facility shall provide planned and nutritionally balanced meals from the basic food groups in accordance with the " recommended daily dietary allowance " of the American dietetic association, the food and nutrition board of the national research council, or	A 036	The facility will continue to adhere with Nutrition policy 8.2.36 to ensure frozen foods are properly dated and labeled, freezer and refrigerator are placed on a regular cleaning schedule and medication are stored in a separate freezer/ refrigerator than food. Additional ongoing training will be provided to educate staff on proper dietary and sanitary procedures are followed. (continued to the next page)	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2219	A. BUILDING: _____ B. WING _____	C 10/21/2022

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

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A 036	Continued From page 16 the national academy of sciences. Meals shall meet the nutritional needs of the residents in accordance with the " 2005 USDA dietary guidelines for Americans. " Vending machines shall not be considered a source of snacks. A. Dietary services policies and procedures. The facility will develop and implement written policies and procedures that are maintained on the premises and that govern the following requirements. (1) Meal service. The facility shall: (a) serve at least three (3) meals or their equivalent each day at regular times with no more than sixteen (16) hours between the evening meal and morning meal with snacks freely available; (b) provide snacks of nourishing quality and post on the daily menu; (c) develop menus enjoyed by the residents and served at normal intervals appropriate to the residents ' preferences; (d) post the weekly menu, including snacks where residents and families are able to view it; posted menus shall be followed and any substitution shall be of equivalent nutritional value and recorded on the posted menu; identical menus shall not be used within a one (1) week cycle; (e) have special menus or meal items following guidelines from the resident ' s physician for residents who have medically prescribed special diets; (f) serve all residents in a dining room except for residents with a temporary illness, or with documented specific personal preference to have meals in their room; (g) allow sufficient time for meals to enable residents to eat at a leisurely pace and to socialize; and	A 036	Action began on Nov 1, 2022, and a cleaning scheduled has been implemented weekly to check and log any issues or when completed. Administrator or designee will monitor	

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	2219	A. BUILDING: _____ B. WING _____	C 10/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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A 036	Continued From page 17 (h) contact the resident ' s PCP within forty-eight (48) hours if a resident consistently refuses to eat. (2) Staff in-service training. The facility shall provide an in-service training program for staff that are involved in food preparation at orientation and at least annually and that includes: (a) instruction in proper food storage; (b) preparation and serving food; (c) safety in food handling; (d) appropriate personal hygiene; and (e) infectious and communicable disease control. B. Dietary records. The facility shall maintain the following documentation onsite: (1) a systematic record of all menus and revisions, including snacks, for a minimum of thirty (30) calendar days; (2) a systematic record of therapeutic diets as prescribed by a PCP; (3) a copy of the most recent licensing inspection and for facilities with 10 or more residents, a copy of the New Mexico environment department inspection with notations made by the facility of action taken to comply with recommendations or citations; and (4) a daily log of the recorded temperatures for all facility refrigerators, freezers and steam tables maintained and available for inspection for thirty (30) calendar days. C. Clean and sanitary conditions. All practices shall be in accordance with the standards of the state environment department, pursuant to 7.6.2 NMAC. (1) Kitchen sanitation. (a) Equipment and work areas shall be clean and in good repair. Surfaces with which food or beverages come into contact shall be of smooth, impervious material free of open seams, not readily corrodible and easily accessible for	A 036		

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	2219	A. BUILDING: _____ B. WING _____	C 10/21/2022

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

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A 036	Continued From page 18 cleaning. (b) Utensils shall be stored in a clean, dry place protected from contamination. (c) The walls, ceiling and floors of all rooms that food or drink is stored, prepared or served shall be kept clean and in good repair. (2) Washing and sanitizing kitchenware. (a) All reusable tableware and kitchenware shall be cleaned in accordance with procedures that include separate steps for prewashing, washing, rinsing and sanitizing. (b) Proper dishwashing procedures and techniques shall be utilized and understood by the dishwashing staff. (c) Periodic monitoring of the operation of the detergent dispenser, washing, rinsing and sanitizing temperatures shall be performed and documented. (d) When a dishwashing machine is utilized, the cleanliness of the machine, its jets and its thermostatic controls shall be monitored and documented by the facility. A monthly log of the recorded temperature of the dishwasher shall be maintained in the facility and available for inspection. (3) Sinks for hand washing shall include hot and cold running water, hand-washing soap and disposable towels. (4) All garbage and kitchen refuse that is not disposed of through a garbage disposal unit shall be kept in watertight containers with close-fitting covers and disposed of daily in a safe and sanitary manner. (5) Cooks and food handlers shall wear clean outer garments and hair nets or caps and shall keep their hands clean at all times when engaged in handling food, drink, utensils or equipment in accordance with the local health authority. Disposable gloves shall be used in accordance	A 036		

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	2219	A. BUILDING: _____ B. WING _____	C 10/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HACIENDAS AT GRACE VILLAGE, LLC - UNIT C	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 036	Continued From page 19 with the local health authority. D. Food management. The facility shall store, prepare, distribute and serve food under sanitary conditions and in accordance with the regulations governing food establishments of local health authority having jurisdiction, 7.6.2 NMAC. (1) The facility shall ensure that a minimum of a three (3) calendar day supply of perishables and a five (5) calendar day supply of non-perishables or canned foods is available for the residents. (2) The facility refrigerator and freezer shall have an accurate thermometer which reads within or not more than plus or minus three (3) degrees fahrenheit of the required temperature, located in the warmest section of the refrigerator and freezer and shall be accessible and easily read. (a) The temperature of the refrigerator shall be thirty-five (35) - forty-one (41) degrees fahrenheit. (b) Freezer temperatures shall be maintained at zero (0) degrees fahrenheit or below. (3) Refrigerators and freezers shall be kept clean and sanitary at all times. Food stored in refrigerators and freezers shall be covered, dated and labeled. Unused leftover food shall be discarded after three (3) calendar days. (4) Steam tables, hot food tables, slow cookers, crock pots and other hot food holding devices shall not be used in heating or reheating food. Hot food temperatures shall be checked periodically to insure that a minimum of one hundred forty (140) degrees fahrenheit is maintained. (5) Medication, biological specimens, poisons, detergents and cleaning supplies shall not be kept in the same storage areas used for storage of foods. Medications shall not be stored in the refrigerator with food; an alternate refrigerator for medication shall be used pursuant to Subsection B of 7.6.2.8 NMAC.	A 036		

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	2219	A. BUILDING: _____ B. WING _____	C 10/21/2022

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

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A 036	Continued From page 20 (6) Canned or preserved foods shall be procured from sources that process the food under regulated quality and sanitation controls. This does not preclude the use of local fresh produce. The facility shall not use home-canned foods. (7) Dry or staple food items shall be stored at least six (6) inches off the floor in a ventilated room that is not subject to sewage, waste water back-flow or contamination by condensation, leakage, rodents or vermin. (8) The facility shall ensure the following: (a) all perishable food is refrigerated and the temperature is maintained no higher than forty-one (41) degrees fahrenheit; (b) the temperature for all hot foods is maintained at one hundred forty (140) degrees fahrenheit; and (c) all displayed or transported food is protected from environmental contamination and maintained at proper temperatures in clean containers, cabinets or serving carts. E. Milk. (1) Raw milk shall not be used. (2) Condensed, evaporated, or dried milk products that are nationally recognized may be employed as " additives " in cooked food preparation but shall not be substituted or served to residents in place of milk. F. Collateral requirements. Compliance with this rule does not relieve a facility from the responsibility of meeting more stringent municipal regulations, ordinances or other requirements of state or federal laws governing food service establishments. Local health authority having jurisdiction means municipal, county, state or federal agency(s) that have laws and regulations governing food establishments, liquid waste disposal, treatment facilities and private wells. [7.8.2.36 NMAC - Rp, 7.8.2.37 NMAC,	A 036		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2219	A. BUILDING: _____ B. WING _____	C 10/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HACIENDAS AT GRACE VILLAGE, LLC - UNIT C	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 036	Continued From page 21 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.36 D (3) (5) Based on observation and interview the facility failed to ensure that: 1. Frozen foods were appropriately dated, and labeled. 2. The freezer was clean and sanitary. 3. Medication was not stored in the same freezer used for food. These deficient practices could likely result in the 10 (R #s 1- 10) residents identified on the resident census provided by the Administrator 09/27/22, to be at risk of contracting foodborne illness and needing medical attention if: 1. Residents consume foods that are not labeled and dated, stored properly and are past their expiration dates. 2. Residents are exposed to potentially unsafe foods, if the freezer where food is stored is not kept clean and sanitary. 3. Food becomes contaminated with germs/bacteria, from medicated swabs being kept in the same freezer. The findings are: A. On 09/27/22 at 11:05 am, during observation in the kitchen, the following was observed: 1. Frozen foods were not appropriately dated, and labeled. 2. The freezer was not clean and sanitary. 3. Medication (medicated swabs)were stored in the same freezer used for food.	A 036		

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	2219	A. BUILDING: _____ B. WING _____	C 10/21/2022

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

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A 036	Continued From page 22 B. On 09/27/22 at 11:42 am, during an interview with DCS #1, she confirmed that: 1. The freezer was not kept clean and in sanitary condition. 2. Some foods in the freezer were not marked, dated and labeled. She could not identify what some of the foods in packages were. 3. Resident medicated swabs were stored in the freezer with food.	A 036		
A 038	7 NMAC 8.2.38 Housekeeping Services HOUSEKEEPING SERVICES. The facility shall maintain the interior and exterior of the facility in a safe, clean, orderly and attractive manner. The facility shall be free from offensive odors, safety hazards, insects and rodents and accumulations of dirt, rubbish and dust. A. All common living areas and all bathrooms shall be cleaned as often as necessary to maintain a clean and sanitary environment. B. Combustibles such as cleaning rags or flammable substances shall be stored in closed metal containers in approved areas that provide adequate ventilation. Combustibles shall be stored away from the food preparation areas and away from the resident rooms. C. Poisonous or flammable substances shall not be stored in residential areas, food preparation areas or food storage areas. If hazardous chemicals are stored on the property, material safety data sheets shall be maintained and stored in the same area as the chemicals, pursuant to state environment department requirements, 11.5.2.9 NMAC. [7.8.2.38 NMAC - Rp, 7.8.2.39 NMAC, 01/15/2010]	A 038	The facility will adhere with Housekeeping policy 8.2.38 to ensure proper maintenance to interior and external of the facility in a safe, clean, orderly and attractive manner free from hazards, insects, rodents and dirt. Additional ongoing staff training will be conducted to ensure proper storage of "poisonous or flammable substances" are secured in a locked closet. Facility has address concerns on Oct 3, 2022 and added a weekly log to document any concerns and date that concern were addressed. This audit will be done weekly. Administrator or designee will monitor.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2219	A. BUILDING: _____ B. WING _____	C 10/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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 038	Continued From page 23 This REQUIREMENT is not met as evidenced by: HOUSEKEEPING SERVICES 7.8.2.38 C. Based on observation and interview, the facility failed to ensure that "Poisonous or flammable substances" were not stored in residential areas or in food preparation storage areas and kept in a secured room or cabinet. These deficient practices could potentially result in the 10 (R #'s 1 - 10) residents listed on the resident census list provided by the Administrator on 09/27/22, to be at risk of harm, injury, or death if, the facility does not secure "Poisonous or flammable substances" from residents accessing them, there is a potential for ingesting chemicals, inhaling fumes, or being exposed to chemicals spills. The findings are: A. On 09/27/22 at 11:35 am during observation of the facility's kitchen, one (1) gallon of bleach was found under an unlocked cabinet. Across the kitchen in the hallway, an unlocked closet was observed with the following cleaning chemicals: 1. 2 bottles of purple acid liquid cleaner 2. 5 liquid cleaning sprays 3. 1 gallon of liquid bleach B. On 09/27/22 at 11:42 am, during an interview with Direct Care Staff (DCS) #1, she confirmed the findings above.	A 038		
A 066	7 NMAC 8.2.66 Staff and Resident Fire and Safety Training	A 066	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	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2219	A. BUILDING: _____ B. WING _____	C 10/21/2022

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

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A 066	Continued From page 24 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 total minutes.	A 066	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	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2219	A. BUILDING: _____ B. WING _____	C 10/21/2022

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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 066	Continued From page 25 (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 C Based on record request, record review, and interview the facility failed to ensure that the residents/families were informed on admission of the location of the facility fire exits, fire extinguishers, and instructed in the actions to take in case of a fire or other emergency. 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 residents have not received evacuation training, and do not know how to safely evacuate the facility. The findings are: A. Record review of R #s 1-4 resident files, revealed no documentation that the resident/families had fire safety orientation that included: 1. The location and use of fire extinguishers, 2. Location of fire exits, 3. Instruction on the actions to take in case of a fire or other emergency. B. On 09/28/22 at 5:18 pm, during an interview with the Administrator, she confirmed that their	A 066		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2219	A. BUILDING: _____ B. WING _____	C 10/21/2022

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A 066	Continued From page 26 was no documentation residents/families received orientation on admission of the location of the facility fire exits, fire extinguishers, and instructed in the actions to take in case of a fire or other emergency.	A 066		