STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	7020	A. BUILDING: _____ B. WING _____	08/18/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARLER MANOR	3712 GENERAL PATCH ST NE ALBUQUERQUE, NM 87111

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A 000	Initial Comments The following deficiencies were cited during an onsite Initial survey conducted on 08/18/22 for the state requirements of 7 NMAC 8.2, Regulations for Assisted Living Facilities for Adults. DCS: Direct Care Staff MAR: Medication Administration Record MC: Memory Care Lb: Pound Fl oz: Fluid Ounce Oz: Ounce Gal: Gallon L: Liter PCP: Primary Care Physician	A 000	Initial Comments The providers plan of correction to survey is provided in the following pages in the second column of this document.	
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	A 017	NMAC7.8.2.17 Staff Training Continue to page 2	

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A 017	Continued From page 1 information; (5) infection control; (6) resident rights; (7) reporting requirements for abuse, neglect or exploitation in accordance with 7.1.13 NMAC; (8) smoking policy for staff, residents and visitors; (9) methods to provide quality resident care; (10) emergency procedures; (11) medication assistance, including the certificate of training for staff that assist with medication delivery; and (12) the proper way to implement a resident ISP for staff that assist with ISPs. D. If a facility provides transportation to residents, employees of the facility who drive vehicles and transport residents shall have training in transportation safety for the elderly and disabled, including safe vehicle operation. [7.8.2.17 NMAC - Rp, 7.8.2.17 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.17 C Based on record review and interview, the facility failed to ensure that the DCS received 12 hours of annual training in the topics required by regulation and proof of competency in employee file. This deficient practice could likely result in the [redacted] (R #s [redacted] residents listed on the resident census, provided by the Administrator on 08/15/22, 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 the Administrator's employee	A 017	Continued from page 1 Requirement evidence answered 7.8.2.17 C Staff training Continue to page 3	

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A 017	Continued From page 2 file (hire date 11/25/08), revealed she had not completed any of the annual trainings in the topics required by regulation. B. Record review of the Owner's employee file (hire date 11/23/00), revealed he had not completed any of the annual trainings in the topics required by regulation. C. On 08/18/22 at 1:00 pm, during an interview with the Administrator, she confirmed that 1. She and the Owner are the only staff working and providing care for residents at the facility. 2. Neither herself or the Owner had been conducting or completing any annual trainings.	A 017	Continued from page 2 A&B The Administrator has training certificates and proof of training in training file. The Owner has training certificates and proof of training in training file C.2 The Administrator conducted orientation and annual trainings (1/18/22- 2/4/22) (10/11/2022-2/11/2023) Plan of correction Administrator maintains training log of annual trainings,/completion dates and competency records in master log on a quarterly basis	6/9/23
A 019	7 NMAC 8.2.19 Staffing Ratios STAFFING RATIOS: The following staffing levels are the minimum requirements. A. The facility shall employ the sufficient number of staff to provide the basic care, resident assistance and the required supervision based on the assessment of the residents ' needs. (1) During resident waking hours, facilities shall have at least one (1) direct care staff person on duty and awake at all times for each fifteen (15) residents. (2) During resident sleeping hours, facilities with fifteen (15) or fewer residents shall have at least one (1) direct care staff person on duty, awake and responsible for the care and supervision of the residents. (3) During resident sleeping hours, facilities with sixteen (16) to thirty (30) residents shall have at least one (1) direct care staff person on duty and awake at all times and at least one (1) additional staff person available on the premises.	A 019	7.8.2.19 Staffing Ratios Continue to page 4	

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A 019	Continued From page 3 (4) During resident sleeping hours, facilities with thirty-one (31) to sixty (60) residents shall have at least two (2) direct care staff persons on duty and awake at all times and at least one (1) additional staff person immediately available on the premises. (5) During resident sleeping hours, facilities with more than sixty-one (61) residents shall have at least three (3) direct care staff persons on duty and awake at all times and one (1) additional staff person immediately available on the premises for each additional thirty (30) residents or fraction thereof in the facility. B. Upon request of the department, the facility shall provide the staffing ratios per each twenty-four (24) hour day for the past thirty (30) days. [7.8.2.19 NMAC - Rp, 7.8.2.18 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.19 A (2) Based on observation, record review, and interview, the facility failed to ensure that for facilities with fewer than 15 residents, that there was at least one DCS on duty, awake, and able to provide care and supervision to the residents during resident sleeping hours. This deficient practice could likely negativity effect the safety and welfare of the [redacted] (R #s [redacted]) residents identified on the resident census provided by the Administrator on 08/15/22, to be at risk of harm, injury if there are not adequate staffing available to assist residents. The findings are:	A 019	Continued from page 3 Requirement evidence answered 7.8.2.19 A 2 Staffing Ratios Continue to page 5	

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A 019	Continued From page 4 A. Record review of the facility staff census revealed there are two employed staff on duty (The Administrator and the Owner). B. Record review of the staff schedule for August, 2022 revealed there are two staff on duty (The Administrator and the Owner) 24-hours a day, Monday through Friday. C. On 08/16/22 at 2:03 pm, during an interview with the Administrator, she confirmed: 1. The Administrator and the Owner both work 24-hours a day. 2. The Administrator and the Owner get up several times a night and they lay eyes on the residents either by camera or observation. 3. There is not an awake staff on duty 24-hours a day, specifically during sleeping hours, to provide supervision and care to the residents.	A 019	Continued from page 4 A&B There is at least one staff member administrator or owner available at all times 7 days and nights a week C 1,2,3 The Administrator or the Owner do not work 24 hours a day There is either the Administrator or the Owner or staff awake and available monitoring and caregiving the residents at all times There is an awake staff on duty 24 hours a day	5/11/21 5/11/21
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;	A 020	7.8.2.20 Admissions and Discharge Continue to page 6	

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A 020	Continued From page 5 (5) the refund provision in case of death, transfer, voluntary or involuntary discharge; (6) information to formulate advance directives; (7) a written description of the legal rights of the residents translated into another language, if necessary; (8) the facility's staffing ratio; (9) written authorization for staff to assist with medications; (10) notification of rights and responsibilities pursuant to the Incident Reporting Intake, Processing and Training Requirements, 7.1.13 NMAC; (11) the facility ' s bed hold policy; and (12) the admission agreement may be terminated if an appropriate placement is found for the resident, under the following circumstances: (a) there shall be a fifteen (15) day written notice of termination given to the resident or his or her 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	A 020	Continued from page 5 Continue to page 7	

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A 020	Continued From page 6 new or amended admission agreement must be executed whenever services, costs or other material terms are changed; and (14) facilities representing their services as " specialized " must disclose evidence of staff specialty training to prospective residents. B. Restrictions in admission. The facility shall not admit or retain individuals that require twenty-four (24) hour continuous nursing care, refer to Subsection U of 7.8.2.7 NMAC Definitions. This rule does not apply to hospice residents who have elected to receive the hospice benefit. Conditions or circumstances that usually require continuous nursing care may include but are not limited to the following: (1) ventilator dependency; (2) pressure sores and decubitus ulcers (stage III or IV); (3) intravenous therapy or injections; (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	A 020	Continued from page 6 Continue to page 7	

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A 020	Continued From page 7 be re-admitted or remain in the facility and the facility wishes to re-admit or retain the resident. The facility shall comply with the following requirements. (1) Convene a team, comprised of: (a) the facility administrator and a facility health care professional if desired; (b) the resident or resident ' s surrogate decision maker; and (c) the hospice or home health clinician. (2) The team shall jointly determine if the resident should be admitted, readmitted or allowed to remain in the facility. Team approval shall be in writing, signed and dated by all team members and the approval shall be maintained in the resident's record and shall: (a) be based upon an individual service plan (ISP) which identifies the resident's specific needs and addresses the manner that such 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.	A 020	Continued from page 7 Continue to page 8	

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A 020	Continued From page 8 (1) Assisted living facilities shall have evidence of care coordination on an ISP for all services that are provided in the facility by an outside health care provider, such as hospice or home health providers. (2) Residents shall be given a list of providers, including hospice and home health if applicable, and have the right to choose their provider. If applicable, the referring party shall disclose any ownership interest in a recommended or listed provider. [7.8.2.20 NMAC - Rp, 7.8.2.19 NMAC & 7.8.2.20 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.20 A (5) Refer to Senate Bill (SB) 0335 - 2013 AN ACT RELATING TO HEALTH CARE; REQUIRING CONTRACTS FOR ASSISTED LIVING FACILITIES TO CONTAIN A REFUND POLICY UPON TERMINATION OF A CONTRACT DUE TO THE DEATH OF THE RESIDENT; PROVIDING FOR STORAGE OF A RESIDENT'S BELONGINGS; DECLARING AN EMERGENCY. BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF NEW MEXICO: SECTION 1. A new section of the Public Health Act is enacted to read: "ASSISTED LIVING FACILITIES CONTRACTS--LIMIT ON CHARGES AFTER RESIDENT DEATH.-- A. The contract for each resident of an assisted living facility shall include a refund policy	A 020	Continued from page 8 Requirement evidence answered 7.8.2.20 A 5 Admissions and Discharge Senate Bill (SB) 0335-2013 refund policy Continue to page 10	

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A 020	Continued From page 9 to be implemented at the time of a resident's death. The refund policy shall provide that the resident's estate or responsible party is entitled to a prorated refund based on the calculated daily rate for any unused portion of payment beyond the termination date after all charges have been paid to the licensee. For the purpose of this section, the termination date shall be the date the unit is vacated by the resident due to the resident's death and cleared of all personal belongings. B. If a resident's belongings are not removed within one week of the resident's death and the amount of belongings does not preclude renting the unit, the facility may clear the unit and charge the resident's estate for moving and storing the items at a rate equal to the actual cost to the facility, not to exceed ten percent of the regular rate for the unit; provided that the responsible party for the resident is given notice at least one week before the resident's belongings are removed. If the resident's belongings are not claimed within forty-five days after notification, the facility may dispose of them. C. For the purposes of this section, "assisted living facility" means a facility required to be licensed as an assisted living facility for adults by the department of health." SECTION 2. EMERGENCY.--It is necessary for the public peace, health and safety that this act take effect immediately. Based on record review and interview, the facility failed to ensure for [redacted] (R #s [redacted]) of [redacted] re (R #s [redacted]) residents whose Admission/Discharge Agreements were reviewed for compliance, included a refund provision in case of death that is in compliance with 7.8.2.20 and Senate Bill (SB) 0335 - 2013.	A 020	Continued from page 9 Continue to page 11	

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A 020	Continued From page 10 This deficient practice could likely result in the residents/resident's estate to be at risk of not receiving monies owed or aware of additional charges that may be incurred upon the death of a resident. The findings are: A. Record review of R #[redacted] admission agreement dated [redacted], revealed there was not a refund provision in case of death that is in compliance with 7 NMAC 8.2.20 Regulations for Assisted Living Facilities and a Senate Bill (SB) 0335 - 2013. B. Record review of R[redacted] admission agreement dated [redacted] revealed there was not a refund provision in case of death that is in compliance with 7 NMAC 8.2.20 Regulations for Assisted Living Facilities and a Senate Bill (SB) 0335 - 2013. C. On 08/18/22 at 1:00 pm, during an interview with the Administrator, she confirmed that the resident admission agreements for R #s [redacted] did not contain a refund provision in case of death that is in compliance with 7 NMAC 8.2.20 Regulations for Assisted Living Facilities and a Senate Bill (SB) 0335 - 2013.	A 020	Continued from page 10 A. rrective action R[redacted] Agreement / An addendum regarding the refund policy was completed to compliance with SB 0335-2013. POA was contacted and approval was given by phone. Addendum in resident file B. C rrective action R#[redacted] Agreement / An addendum regarding the refund policy was completed to compliance with SB 0335-2013. POA was contacted and approval was given by phoned. Addendum in resident file C. Corrective action Administrator will be performing quality Checks on each admission within the first 10 to14 days to ensure compliance with SB 0335-2013	9/6/22 9/6/22 9/6/22
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:	A 022	7.8.2.22 Facility Reports, Records, Rules, Policies Continue to page 12	

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A 022	Continued From page 11 (1) fire inspection report; (2) zoning approval; (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 (FSES) 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	A 022	Continued from page 11 Continued to page 13	

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A 022	Continued From page 12 emergencies: (a) an emergency that affects just the facility; and (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;	A 022	Continued from page 12 Continued to page 14	

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A 022	Continued From page 13 (5) meal availability and times; (6) resident use of common areas; (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;	A 022	Continued from page 13 Continued to page 15	

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A 022	Continued From page 14 (15) program narrative; (16) resident's rights with regard to making health 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]	A 022	Continued from page 14	
	This REQUIREMENT is not met as evidenced by: 7.8.2.22 A (10) Based on record review and interview, the facility failed to have a complete written emergency disaster plan in the event of a an emergency that affects the facility, and a region/area wide emergency. This deficient practice could likely negatively affect the health and safety of the [redacted] (R #s [redacted])		Requirement evidence answered 7.8.2.22 A 10 Emergency Plans Continue to page 16	

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A 022	Continued From page 15 residents listed on the resident census, provided by the Administrator on 08/15/22, if there is no emergency evacuation plan for community-wide disasters. The findings are: A. Record request of the facility's written Emergency Disaster Plan resulted in no documentation that the facility had a written plan in place. B. On 08/16/22 at 2:03 pm, during an interview with the Administrator, she confirmed that there was not a written emergency disaster plan.	A 022	Continued from page 15 Findings A&B There are several documented Emergency Disaster Plans in the Policies and Procedure file that was presented at survey Corrective Action Administrator orgainzed the file into emergency packets / dividing the information according to type of emergency including community wide disaster	6/9/23
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	A 034	7.8.2.34 Custodial Drug Permits Continue to page 17	

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A 034	Continued From page 16 mouth shall be separated from all other delivery forms. (3) A separate, locked refrigerator shall be provided by the facility for medications. The refrigerator temperature shall be kept in compliance with the state board of pharmacy requirements for medications. (4) All medications, including non-prescription medications, shall be stored in separate compartments for each resident and all medications shall be labeled with the resident's name. (5) A resident may be permitted to keep his or her own medication in a locked compartment in his or her room for self-administration, if the physician's order deems it appropriate. (6) The facility shall not require the residents to purchase medications from any particular pharmacy. (7) Medical gases (oxygen) and equipment used for the administration of inhalation therapy and for resuscitative purposes shall comply with the national fire protection association (NFPA) 99. (8) A proof of use record shall be maintained separately for each schedule II through IV drug (controlled substances). The proof of use sheet shall document: (a) the type and strength of the schedule II through IV drugs; (b) the date and time staff assisted with self-administration; (c) the resident ' s name; (d) the prescriber ' s name; (e) the dose; (f) the signature of the person assisting with delivery of the medication; and (g) the balance of medication remaining. (9) Any remaining medication discontinued by a physician ' s order, or upon discharge or death of	A 034	Continued from page 16 Continued to page 18	

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A 034	Continued From page 17 the resident shall be inventoried and moved to a separate locked storage container. Such discontinued medications shall be destroyed upon the next quarterly visit by the consulting pharmacist in accordance with 16.19.11.10 NMAC. (10) The record of medication destruction shall be signed by the administrator or designee and the pharmacist and shall be kept on file at the facility. B. Consulting pharmacist. The facility shall maintain records demonstrating that the consulting pharmacist provides the following oversight and guidance. (1) Reviews the medication regimen as needed, but at least quarterly/every three (3) months, to determine that all medications and records are accurate and current. All irregularities shall be reported to the administrator of the facility and these irregularities shall be resolved by the administrator within seventy-two (72) hours. (2) A system of records of receipt and disposition of all drugs in sufficient detail to enable an accurate reconciliation. (3) Consultation shall be provided on all aspects of pharmacy services in the facility, including reference information regarding side effects and, when needed, physician consultation in cases involving the use of psychotropic medications. (4) The consulting pharmacist will be responsible for assuring that the facility meets all requirements for storage, labeling, destruction and documentation of medications as required by the state board of pharmacy, 16.19.11.10 NMAC and 7.8.2 NMAC. [7.8.2.34 NMAC - Rp, 7.8.2.35 NMAC, 01/15/2010]	A 034	Continued from page 17 Continue to page 19	

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A 034	Continued From page 18 This REQUIREMENT is not met as evidenced by: 7.8.2.34 A (9) Based on observation, and interview, the facility failed to ensure for [redacted] (R [redacted] of [redacted] (R #s [redacted]) residents whose medications were reviewed for compliance, that any discontinued medications were inventoried and moved to a separate locked storage container. This deficient practice could likely result in the residents to be at risk harm, injury, or death if expired/discontinued prescription medications were given to residents and they are ineffective or cause harm. The findings are: A. On 08/17/22 at 10:00 am, during observation of the medication cart, it was observed that the [redacted] for R [redacted] was dispensed on 02/22/22, and was to be used for only 10 days. B. On 08/18/22 at 1:00 pm, during an interview with the Administrator, she confirmed that the medication had not been discarded after 10 days from 02/22/22.	A 034	Continued from page18 Requirement evidence answered 7.8.2.34 A 9 Custodial Drug Permit A&B Administrator monitors when medication ordered to be used for a certain time frame. Any remaining medication such as (creams, ointments and sprays) and is not expired or there is not a discharge order / that medication is stored in a plastic container in a locked cabinet placed separate from the current medications awaiting physician order. Corrective action In the future, within 30 days of completion of order any remaining medication is stored properly awaiting orders in a locked cabinet Administrator will contact physician requesting order Medication will be logged accordingly in resident MAR	8/17/2022
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 035	7.8.2.35 Medication Continue to page 20	

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A 035	Continued From page 19 A. State board of nursing licensed or certified health care professionals are responsible for the administration of medications. Administration may only be performed by these individuals. B. Facility staff may assist a resident with the self-administration of medications if written consent by the resident is given to the administrator of the facility or the administrator ' s designee. If the resident is incapable of giving consent, the surrogate decision maker named in accordance with New Mexico law may give written consent for assistance with self-administration of medications. All staff that assist with self-administration of medications shall have successfully completed a state approved assistance with self-administration of medication training program or be licensed or certified by the state board of nursing. C. PRN (pro re nada) medication. (1) Physician or physician extender ' s orders for PRN medications shall clearly indicate the circumstances in which they are to be used, the number of doses that may be given in a 24-hour period and indicate under what circumstances the primary care practitioner (PCP) is to be notified. (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	A 035	Continued from page 19 Continue to page 21	

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A 035	Continued From page 20 medications shall know interactions or possible side effects that might occur. F. Medications prescribed for one resident shall not be used for another resident. G. Medication assistance record (MAR). For residents who are not independent and require assistance with self administration, the facility shall have a MAR that documents the details of the residents' medication, including PRN and over-the-counter medication that is assisted with self-administration by qualified staff or administered to the resident by licensed or certified staff. The information in the MAR shall include: (1) the resident's name; (2) any known allergies to medication that the resident has; (3) the name of the resident's PCP or the prescriber of the medication; (4) the diagnosis or reason for the medication; (5) the name of the medication, including the drug product brand name and the generic name; (6) notation if the medication is a schedule II-IV drug; (7) the dosage of the medication; (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	A 035	Continued from page 20 Continue to page 22	

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A 035	Continued From page 21 self-administered, administered with assistance or is administered; (16) the initials and signature of the person assisting with or administering the medication; (17) the desired results obtained from or problems encountered with the medication (pain relieved, allergic reaction, etc.); (18) any refused dose of medication; (19) any missed dose of medication; and (20) any medication error. H. No medication shall be stopped or started without specific orders from the primary care physician. I. If a resident refuses to take a prescribed medication, it shall be documented and the facility shall report it to the prescriber. J. A suspected adverse reaction to a medication shall be documented on the MAR and reported immediately to the PCP and the resident's surrogate decision maker. If applicable, emergency medical treatment shall be arranged. Documentation of the event shall be kept in the resident's record. K. Prescription medication, other than blister packs and unit dose containers, shall be kept in 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	A 035	Continued from page 21 Continue to page 23	

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A 035	Continued From page 22 errors and the prescriber's response shall be kept in the resident's record. N. The facility shall develop and follow a written policy for unused, outdated, or recalled medications kept in the facility in accordance with 16.19.11.10 NMAC (AS AMENDED). [7.8.2.35 NMAC - Rp, 7.8.2.35 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.35 G H Based on record review and interview, the facility failed to ensure for [redacted] (R [redacted]) of [redacted] (R #s [redacted]) residents whose MARs was reviewed for compliance: 1. Contained all medications with a physician's order. 2. Medications were stopped or started with specific orders from the Primary Care Physician (PCP). 3. Refused medications were documented and reported it to the prescribe/PCP. This deficient practice could likely cause harm to the residents if: 1. The MAR does not contain accurate information and the resident goes without an ordered medication and/or extra dose was administered in error. 2. A medication was stopped without specific orders from the prescribe/PCP. 3. Refused medications were not documented or reported to the prescribe/PCP. The findings are:	A 035	Continued from page 22 Requirement evidence answered 7.8.2.35 G H Medications Continue to page 24	

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A 035	Continued From page 23 A. Record review of R # Physician Orders revealed: 1. Order note dated 05/14/21, revealed there was an order for [redacted] 2. Order note dated 07/09/21, revealed there was an order for [redacted]. B. Record review of R MAR dated 08/01/22 through 08/11/22 revealed: 1. The written dosage was for [redacted] 2. There was no documentation of the [redacted] C. On 08/17/22 at 10:04 am, during observation of the medication cabinet. revealed that there was no [redacted] available for R D. On 08/18/22 at 1:00 pm, during an interview with the Administrator, she confirmed: 1. They were not following the physician orders for [redacted] as needed and assisting R with self-administering the medication [redacted]. 2. For the Order of the [redacted] a. It was not on the MAR or in the medication cabinet. b. The medication was stopped due to the resident refusing to take it and was not documented or reported to the prescribe/PCP c. The medication was stopped without	A 035	Continued from page 23 A& [redacted] and [redacted] was completed with new orders within 10 minutes of findings. D. Corrective action Administrator maintains MAR records on daily basis Residents have the right of refusal Any communication regarding medication changes is kept in resident files. Continue to page 25	8/17/22

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A 035	Continued From page 24 specific orders from the prescribe/PCP.	A 035	Continued from page 24	
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] This REQUIREMENT is not met as evidenced by: 7.8.2.38 C Based on observation and interview, the facility failed to ensure that cleaning supplies/hazardous chemicals were stored in secure areas and were not accessible to the residents.	A 038	7.8.2.38 Housekeeping Services Requirement evidence answered 7.8.2.38 C Continue to page26	

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A 038	Continued From page 25 This deficient practice could likely result in the [redacted] (R #s [redacted]) residents listed on the census list provided by the Administrator on 08/15/22, to be at risk of harm, illness, or injury if the residents were to spill or ingest the hazardous chemicals. The findings are: A. On 08/15/22 at 10:52 am, during observation of the facility, the following chemicals were observed stored in an unsecured hall closet: 1. 19 oz (ounce) can of disinfectant spray 2. 20 oz can of fabric finish B. On 08/15/22 at 10:55 am, during observation of the facilities laundry room, the following chemicals were observed stored in an unsecured cabinet: 1. Three (3) 1 lb (pound) containers of disinfecting wipes 2. 32 fl oz (fluid ounce) bottle of foaming bleach 3. 128 fl oz bottle of wood cleaner 4. 14 oz can of stainless steel polish 5. 32 fl oz bottle of unlabeled liquid 6. 22 fl oz bottle of all purpose cleaner 7. 32 fl oz bottle of liquid odor control 8. 22 fl oz bottle of wood cleaner 9. 10.5 oz can of all purpose adhesive 10. 10 oz can of Lubricant spray 11. 12 fl oz bottle of adhesive remover 12. 12 oz can of protective enamel 13. 19 oz can of glass cleaner 14. 10 oz can of insect killer 15. 1.64 gal bottle of all purpose cleaner 16. 7.81 lb bottle of dish detergent 17. 3.5 AL bottle of bleach 18. 128 oz bottle of all purpose cleaner 19. 3.5 AL bottle of all purpose cleaner 20. 1 gal bottle of laundry stain remover	A 038	Continued from page 25 A. Disinfectant spray and fabric finish were removed from top shelf of hall cabinet immediately during survey Corrective action / no chemicals are stored in hall cabinet B. Corrective action / Locking hasp was installed within one hour securing the cabinet in the laundry room during survey Continue to page 27	8/15/22 8/15/22

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	7020	A. BUILDING: _____ B. WING _____	08/18/2022

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A 038	Continued From page 26 C. On 08/16/22 at 11:01 am, during an observation of the facility's kitchen, the following chemicals were observed stored in an unsecured cabinet: 1. 64 gal (gallon) bottle of all purpose cleaner 2. 32 oz bottle of all purpose cleaner 3. 21 oz can of bleach 4. 1 gal bottle of dish detergent 5. 125 oz bottle of dish detergent 6. 32 fl oz bottle of rinse aid D. On 08/18/22 at 1:00 pm, during an interview with the Administrator, she confirmed the chemicals were stored in: 1. An unsecured hall closet 2. An unsecured cabinet of the facilities laundry room 3. An unsecured cabinet of the facility's kitchen	A 038	Continued from page 26 C. Corrective Action / under the kitchen sink cabinet is secured D. Corrective Actions have been completed Administrator confirmed that the cabinets had been secured	8/15/22
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 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.	A 065	7.8.2.65 Fire Drills Continue to page 28	

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A 065	Continued From page 27 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]	A 065	Continued from page 27	
	This REQUIREMENT is not met as evidenced by: 7.8.2.65 B (4-5) Based on record review and interview, the facility failed to ensure that when conducting monthly fire drills that there was documentation of the evacuation time in total minutes. This deficient practice could likely result for all [redacted] (R #s [redacted] residents identified on the census, provided by Administrator on 08/15/22, to be at risk of harm, injury, or death if the DCS do not know how to safely evacuate the residents from the building if a fire were to occur, if they do not know how long it will take to evacuate the residents from the facility. The findings are A. Record review of the facility's emergency fire drill records (dated 05/10/22, 06/08/22 and 07/19/22), revealed no documentation of the evacuation times in total minutes B. On 08/18/22 at 1:03 pm, during an interview with the Administrator, she confirmed that the facility's fire drill records did not include the evacuation time in total minutes.		Requirement evidence answered 7.8.2.65 4-5 Fire Drills A&B The facility has an automatic fire protection sprinkler system Corrective action / In the future the Administrator will double check fire drill documentation to ensure the evacuation time is documented Continue to page 29	8/15/22

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A 068	Continued From page 28	A 068	Continued from page 28	
A 068	7 NMAC 8.2.68 Hospice HOSPICE: An assisted living facility that provides or coordinates hospice care and services shall meet the requirements in this section, in addition to the rules applicable to all assisted living facilities, 7.8.2 NMAC. A. Definitions: in addition to the requirements for all assisted living facilities pursuant to " DEFINITIONS, " 7.8.2.7 NMAC, the following definitions shall also apply. (1) " Hospice agency " means an organization, company, for-profit or non-profit corporation or any other entity which provides a coordinated program of palliative and supportive services for physical, psychological, social and the option of spiritual care of terminally ill people and their families. The services are provided by a medically directed interdisciplinary team in the person's home and the agency is required to be licensed pursuant to 7.12 NMAC. (2) " Hospice care " means a focus on palliative, rather than curative care. The goal of the plan of care is to help the patient live as comfortably as possible, with emphasis on eliminating or decreasing pain and other uncomfortable symptoms. (3) " Licensed assisted living provider " means a facility that provides twenty-four (24) hour assisted living and is licensed by the department of health. (4) " Hospice services " means a program of palliative and supportive services which provides physical, psychological, social and spiritual care for terminally ill patients and their family members. (5) " Care coordination requirements " means a written document that outlines the care and services to be provided by the hospice agency for	A 068	7.8.2.68 Hospice Continue to page 30	

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A 068	Continued From page 29 assisted living residents that require hospice services. (6) " Palliative care " means a form of medical care or treatment that is intended to reduce the severity of disease symptoms, rather than to reverse progression of the disease itself or provide a cure. (7) " Terminally ill " means a diagnosis by a physician for a patient with a prognosis of six (6) months or less to live. (8) " Visit notes " means the documentation of the services provided for hospice residents and includes ongoing care coordination. B. Employee training and support. A facility that provides hospice services shall provide the following education and training for employees who assist with providing these services: (1) provide a minimum of six (6) hours per year of palliative/hospice care training, which includes one (1) hour specific to the hospice resident ' s ISP, in addition to the basic staff education requirements pursuant to 7.8.2.17 NMAC; and (2) offer an ongoing employee psychological support program for end of life care issues. C. Individual service plan (ISP) requirements. (1) Each resident who receives hospice services shall be provided the necessary palliative care to meet the individual resident ' s needs as outlined in the ISP and shall include one (1) hour of training specific to the resident for all direct care staff. (2) The assisted living facility, in coordination with the hospice provider, shall create an ISP that identifies how the resident's needs are met and includes the following: (a) the requirements set forth in the " Individual Service Plan, " 7.8.2.26 NMAC, and " Exceptions to admission, readmission and retention, " Subsection C of 7.8.2.20 NMAC;	A 068	Continued from page 29 Continue to page 31	

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A 068	Continued From page 30 (b) what services are to be provided; (c) who will provide the services; (d) how the services will be provided; (e) a delineation of the role(s) of the hospice provider and the assisted living facility in the ISP process; (f) documentation (visit notes) of the care and services that are provided with the signature of the person who provided the care and services; and (g) a list of the current medications or biologicals that the resident receives and who is authorized to administer them. (3) Medications shall be self-administered, self-administered with assistance by an individual that has completed a state approved program in medication assistance or administered by the following individuals: (a) a physician; (b) a physician extender (PA or NP); (c) a licensed nurse (RN or LPN); (d) the resident if their PCP has approved it; (e) family or family designee; and (f) any other individual in accordance with applicable state and local laws. D. Care coordination. (1) The assisted living facility shall be knowledgeable with regard to the hospice requirements pursuant to 7.12 NMAC and ensure that the hospice agency is well informed with regard to the assisted living provisions pursuant to Subsection C of 7.8.2.20 NMAC. (2) The assisted living facility shall hold a team meeting prior to accepting or retaining a hospice resident in accordance with " Exceptions to admission, readmission and retention, " Subsection C of 7.8.2.20 NMAC. (3) Upon admission of a resident into hospice care, the assisted living facility shall designate a	A 068	Continued from page 30 Continue to page 32	

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A 068	Continued From page 31 section of the resident ' s record for hospice documentation. (a) The facility shall provide individual records for each resident. (b) The hospice agency shall leave documentation at the facility in the designated section of the resident ' s record. (4) The assisted living facility shall provide the resident and family or surrogate decision maker with information on palliative care and shall support the resident ' s freedom of choice with regard to decisions. (5) Hospice services shall be available twenty-four (24) hours a day, seven (7) days a week for hospice residents, families and facility staff and may include continuous nursing care for hospice residents as needed. These services shall be delivered in accordance with the resident ' s individual service plan (ISP) and pursuant to 7.8.2 26 NMAC. (6) The assisted living facility shall ensure the coordination of services with the hospice agency. (a) The resident's individual service plan (ISP) shall be updated with significant changes in the resident ' s condition and care needs. (b) The assisted living facility shall receive information and communication from the hospice staff at each visit. (i) The information shall include the resident status and any changes in the ISP (i.e., medication changes, etc.). (ii) The information shall be in the form of a verbal report to the assisted living facility staff and also in the form of written documentation. (c) The assisted living facility or the family/resident shall reserve the right to schedule care conferences as the needs of the resident and family dictate. The care conferences shall include all care team members.	A 068	Continued from page 31 Continue to page 33	

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A 068	Continued From page 32 (d) Concerns that arise with regard to the delivery of services from either the assisted living facility or the hospice agency shall first be addressed with the facility administrator and the hospice agency administrator. (i) The process may be informal or formal depending on the nature of the issue. (ii) If an issue can not be resolved or if there is an immediate danger to the resident the appropriate authority shall be notified. E. Additional provisions. An assisted living facility that provides or coordinates hospice care and services shall make additional provisions for the following requirements: (1) individual services and care: each resident receiving hospice services shall be provided the necessary palliative procedures to meet individual needs as defined in the ISP; (2) private visiting space: (a) physical space for private family visits; (b) accommodations for family members to remain with the patient throughout the night; and (c) accommodations for family privacy after a resident ' s death. F. Medicare and medicaid restrictions. Assisted living facilities shall not accept a resident considered " hospice general inpatient " which would be billable to medicare or medicaid because the facility will not qualify for payment by medicare or medicaid. [7.8.2.68 NMAC - N, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.68 B (1) Based on record review and interview, the facility failed to ensure that the DCS had completed a minimum of six (6) hours per year of	A 068	Continued from page 32 Requirement evidence answered 7.8.2.68 B 1 Continue to page 34	

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A 068	Continued From page 33 palliative/hospice care training. This deficient practice could likely result in the (R [redacted] resident identified as receiving hospice care on the resident census list provided by the Administrator on 08/15/22, to be at risk of harm or injury if DCS have not received training on the proper methods of providing care and services. The findings are: A. Record review of staff training files for the Administrator (hire date 11/25/08) and owner (hire date 11/23/00), revealed they did not received the 6 hours of annual palliative/hospice care training. B. On 08/18/22 at 1:00 pm, during an interview with the Administrator, she confirmed: 1. She and the Owner are the only staff working and providing care for residents at the facility. 2. Neither herself or the owner had been conducting or completing any annual trainings and had not received the required (6) hours of palliative/hospice care training per year.	A 068	Continued from page 33 A&B Corrective action/ Administrator maintains all annual trainings in master training log with completion dates and competency records checked on a quarterly basis	6/9/23
A 069	7 NMAC 8.2.69 Memory Care Units MEMORY CARE UNITS: An assisted living facility that provides a memory care unit to serve residents with dementia shall comply with the provisions of subsection A-J below in addition to the rules applicable to all assisted living facilities, 7.8.2 NMAC. A. Additional definitions: The following definitions, in addition to those in 7.8.2.7 NMAC, shall apply. (1) " Alzheimer ' s " means a brain disorder that destroys brain cells, causing problems with memory, thinking and behavior that are severe enough to affect work, lifelong hobbies or social	A 069	7.8.2.69 Memory Care Units Continue to page 35	

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A 069	Continued From page 34 life. Alzheimer ' s gets progressively worse and is fatal. (2) " Care coordination agreement requirement " means a written document that outlines the care and services that are provided by other outside agencies for assisted living residents that require additional care and services. (3) " Dementia " means loss of memory and other mental abilities severe enough to interfere with daily life. It is caused by changes in the brain. (4) " Memory care unit " means an assisted living facility or part of or an assisted living facility that provides added security, enhanced programming and staffing appropriate for residents with a diagnosis of dementia, Alzheimer ' s disease or other related disorders causing memory impairments and for residents whose functional needs require a specialized program. (5) " Secured environment " means locked (secured/monitored) doors/fences that restrict access to the public way for residents who require a secure unit. B. Care coordination requirement. An assisted living facility that accepts residents with memory issues shall determine which additional services and care requirements are relevant to the resident and disease process. (1) The medical diagnosis and ISP shall be utilized in the determination of the need for additional services. (2) The assisted living facility shall ensure the coordination of services and shall have evidence of an agreement of care coordination for all services provided in the facility by an outside health care provider. C. Employee training. In addition to the training requirements for all assisted living facilities, pursuant to 7.8.2.17 NMAC, all employees	A 069	Continued from page 34 Continue to page 36	

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A 069	Continued From page 35 assisting in providing care for memory unit residents shall have a minimum of twelve (12) hours of training per year related to dementia, Alzheimer ' s disease, or other pertinent information. D. Individual service plan (ISP). An assisted living facility that admits memory care unit residents shall create an ISP in coordination with the resident ' s primary care practitioner, in compliance with the requirements outlined in " Individual Service Plan, " 7.8.2.26 NMAC, pursuant to a team meeting as described in " Exceptions to admission, readmission and retention, " Subsection C of 7.8.2.20 NMAC, and which ensures the following criteria: (1) identification of the resident's needs specific to the memory care unit and the services that are provided; each memory unit resident shall receive the services necessary to meet the individual resident ' s needs; (2) medications shall be self-administered, self-administered with assistance by an individual that has completed a state approved program in medication assistance or administered by the following individuals: (a) a physician; (b) a physician extender (PA or NP); (c) a licensed nurse (RN or LPN); (d) the resident if their PCP has approved it; (e) family or family designee; and (f) any other individual in accordance with applicable state and local laws. E. Assessments and reevaluations. (1) An assessment shall be completed by a registered nurse or a physician extender within fifteen (15) days prior to admission. When emergency placement is warranted the fifteen (15) day assessment shall be waived and the assessment shall be completed within five (5)	A 069	Continued from page 35 Continue to page 37	

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A 069	Continued From page 36 days after admission. (a) The resident shall have a medical evaluation and documentation by a physician, physician's assistant or a nurse practitioner within six (6) months of admission. (b) The pre-admission assessment shall include written findings, an evaluation of less restrictive alternatives and the basis for the admission to the secured environment. The written documentation shall include a diagnosis from the resident's PCP of Alzheimer's disease or other dementia and the need for the resident to reside in a memory care unit. (c) Only those residents who require a secured environment placement or whose needs can be met by the facility, as determined by the assessment prior to admission or on review of the individual service plan (ISP), shall be admitted. (2) A re-evaluation must be completed every six (6) months and when there is a significant change in the medical or physical condition of the resident that warrants intervention or different care needs, or when the resident becomes a danger to self or others, to determine whether the resident ' s stay in the assisted living facility memory care unit is still appropriate. F. Documentation in the resident ' s record. In addition to the required documentation pursuant to 7.8.2.21 NMAC, the following information shall be documented in the resident ' s record: (1) the physician ' s diagnosis for admission to a secure environment or a memory care unit; (2) the pre-admission assessment; and (3) the re-evaluation(s). G. Secured environment. (1) Memory care unit residents may require a secure environment for their safety. A secured environment is any locked (secured/monitored)	A 069	Continued from page 36 Continue to page 38	

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A 069	Continued From page 37 area in which doors and fences restrict access to the public way. These include but are not limited to: (a) double alarm systems; (b) gates connected to the fire alarm; and (c) tab alarms for residents at risk for elopement. (2) In addition to the interior common areas required by this rule, the facility shall provide a safe and secure outdoor area for the year round use by the residents. (a) Fencing or other enclosures shall prevent elopement and protect the safety and security of the residents. (b) Residents shall be able to independently access the outdoor areas. (3) Locked areas shall have an access code or key which facility employees shall have available on their person or on the locking unit itself at all times. H. Resident rights. In addition to the requirements pursuant to 7.8.2.32 NMAC, the following shall apply: (1) the resident's rights may be limited as required by their condition and as identified in the ISP; (2) the resident who believes that he or she has been inappropriately admitted to the secured environment may request the facility in contact the resident ' s legal guardian, or an advocate such as the ombudsman or the primary care practitioner; upon request, the facility shall assist the resident in making such contact. I. Disclosure to residents. A facility that operates a secured environment shall disclose to the resident and the resident ' s legal representative, if applicable and prior to the resident ' s admission to the facility, that the facility operates a secured environment. (1) The disclosure shall include information about	A 069	Continued from page 37 Continue to page 39	

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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 069	Continued From page 38 the types of resident diagnosis or behaviors that the facility provides services for and for which the staff are trained to provide care for. (2) The disclosure shall include information about the care, services and the type of secured environment that the facility and trained staff provide. J. Staffing. The facility shall provide the sufficient number of trained staff members to meet the additional needs of the residents in the secured environment. There must be at least one (1) trained staff member awake and in attendance in the secured environment at all times. [7.8.2.69 NMAC - N, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.69 C Based on record review and interview, the facility failed to ensure that the DCS completed a minimum of twelve (12) hours per year of training related to Dementia or Alzheimer's (memory loss) disease. This deficient practice could likely result in [redacted] (R #s [redacted] residents identified on the resident census list living in the memory care unit provided by the Administrator on 08/15/22, to be at risk of harm or injury if DCS have not received training on the proper methods of providing care and services. The findings are: A. Record review of the Administrator's employee file (hire date 11/25/08), revealed she had not completed the required twelve (12) hours per year of training related to Dementia or Alzheimer's (memory loss) disease.	A 069	Continued from page 38 Requirement evidence answered 7.8.2.69 C Memory Care A. The Administrator has proof of training in training file Continue to page 40	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	7020	A. BUILDING: _____ B. WING _____	08/18/2022

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A 069	Continued From page 39 B. Record review of the Owner's employee file (hire date 11/23/00), revealed he had not completed the required (12) hours per year of training related to Dementia or Alzheimer's (memory loss) disease. C. On 08/18/22 at 1:00 pm, during an interview with the Administrator, she confirmed: 1. She and the Owner are the only staff working and providing care for residents at the facility. 2. Neither herself or the owner had been conducting or completing the required (12) hours per year of training related to Dementia or Alzheimer's (memory loss) disease.	A 069	Continued from page 39 B. The Owner has proof of training in training file C. Corrective Action/ Administrator maintains training log with annual trainings/ completion dates/ competency records in master log on quarterly basis	6/9/23