STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	7094	A. BUILDING: _____ B. WING _____	C 05/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMERICAN SAN PABLO ASSISTED LIVING, LLC	1509 SAN PABLO ST NE ALBUQUERQUE, NM 87110

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 000	Initial Comments The following deficiencies were cited during a Complaint survey completed on [redacted]/24 for the state requirements of NMAC 7.8.2, Regulations for Assisted Living Facilities for Adults. Census: [redacted] Complaint Intake ID [redacted] was investigated, and no deficiencies were cited. Complaint Intake ID [redacted] was investigated, and no deficiencies were cited. Complaint Intake ID [redacted] was investigated, and no deficiencies were cited. Complaint Intake ID [redacted] was investigated, and no deficiencies were cited. Complaint Intake ID [redacted] was investigated, and deficiencies were cited.	A 000	7 NMAC 8.2.20 Admission and Discharge See PG 5 7.1.13 Incident Reporting, Intake, Processing and Training Requirements See Pg 10	
A 020	7 NMAC 8.2.20 Admissions and Discharge ADMISSIONS AND DISCHARGE: The facility shall complete an admission agreement for each resident. The administrator of the facility or a designee responsible for admission decisions shall meet with the resident or the resident ' s surrogate decision maker prior to admission. No resident shall be admitted who is below the age of eighteen (18) or for whom the facility is unable to provide appropriate care. A. Admission agreement. The admission agreement shall include the following information: (1) the parties to the agreement; (2) the program narrative; (3) the facility's rules; (4) the cost of services and the method of payment; (5) the refund provision in case of death, transfer, voluntary or involuntary discharge; (6) information to formulate advance directives;	A 020		

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A 020	Continued From page 1 (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 new or amended admission agreement must be executed whenever services, costs or other material terms are changed; and	A 020		

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A 020	Continued From page 2 (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 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	A 020		

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A 020	Continued From page 3 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. (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	A 020		

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A 020	Continued From page 4 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: 7.2.8.20 B (11) C (1) (a-c) (2) (a & c) (3) Based on record review, observation, and interview, the facility failed to ensure for 1 (R[redacted] of 1 (R[redacted]) residents who require the use of an [redacted] that the facility complied with the following requirements: 1. The team (comprised of the facility administrator, health care professional [if desired], the resident/resident's surrogate decision maker, and the hospice/home health care clinician [if applicable]) convened for an exception team meeting (pursuant to the state regulations) for residents requiring the use of an [redacted] (a restriction to admission or retention) restriction. 2. The team jointly agreed that the resident should be retained as a resident of the facility, and there was written documentation of the agreement, signed and dated by all the members of the team: a. It should be based on an Individual Service Plan (ISP) which identified the resident's specific needs and addressed the manner that	A 020	7 NMAC 8.2.20 Admission and Discharge American San Pablo has conducted a Care Coordination meeting for a plan of care with (R[redacted] on [redacted]/2024 at the Assisted Living Facility. Administrator , daughter and physician was present for the care coordination meeting. Physician has sent out orders for home health care to come out and complete an in-service at American San Pablo LLC to provide the needs of the Ostomy bag. Staff will provide the correct care maintaining time for the [redacted] to be changed as trained by RN as needed on an ongoing bases. Staff will Document every shift regarding each residents and the care given per the residents Care plan. [redacted]/2024 Registered Nurse with home health came out to the facility and trained Administrator and day staff on caring for the [redacted] for (R[redacted]). Family and healthcare service will provide supplies required to care for [redacted]. as supplies are needed staff will request an order.	

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A 020	Continued From page 5 such needs would be met. b. The team evaluated and outlined how meeting the specific needs of the residents would impact the staff and the other residents living there. These deficient practices could likely result in the residents identified on the census provided by the Administrator on [redacted]/24 to be at risk if: 1. There were not enough staff to meet the needs of all residents, including those requiring a higher level of care. 2. The staff neglected other residents due to extra time and extra staff required to provide for the higher level of specialized care necessary for the residents requiring [redacted]. 3. The team did not convene in a meeting (per regulations) to determine if the residents in need of higher care would affect other residents and staff. 4. No documentation/determination that states whether the facility can meet the needs of all residents and residents who require a higher level of care. The findings are: A. Record review of R [redacted] (admitted to facility on [redacted]) physician's hospital discharge summary dated [redacted]/22 revealed: 1. Principal problem: [redacted] obstruction. 2. Admitted for [redacted]	A 020		

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A 020	Continued From page 6 [redacted] 3. Discharge Diagnoses: Procedure(s): [redacted] B. On [redacted]/24 at 1:05 pm, during an observation of R[redacted] it was observed that R[redacted] 1. Right arm was [redacted] 2. Had an [redacted] installed on [redacted] abdomen C. On [redacted]/24 at 2:25 pm, during an interview with R[redacted] stated that[redacted]: 1. Cannot use her right arm because of a [redacted] 2. Has never provided self-care for [redacted] 3. Believes that changing the bag is a simple task and that[redacted] only needs a caregiver to open bottled water for rinsing/cleansing because[redacted] only has use of [redacted] left arm. D. On [redacted]/24 at 1:00 pm, during an interview with the administrator, she confirmed that the facility admitted R[redacted] before her [redacted] procedure and [redacted], and decided to retain [redacted] after the procedure, without having an exception team meeting with: 1. The facility administrator and facility health care professional, if desired. 2. The resident's POA. 3. A hospice or home health clinician. 4. Pursuant to the state regulation, a determination of whether the resident should be allowed to remain in the facility. 5. Pursuant to the state regulation, an evaluation and outline determining how the	A 020		

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A 020	Continued From page 7 specific needs (higher level of care) of the resident would impact the staff and other residents. E. On [redacted]/24 at 12:37 pm, during an interview with R[redacted] Power of Attorney (POA)/daughter, she confirmed that: 1. R[redacted] had a[redacted] procedure on January 15, 2022, due to an obstruction in [redacted] 2. POA has never been involved in an exception meeting for the extra care involved in ostomy care for R[redacted] as required pursuant to state regulations. 3. The POA was not asked to attend an exception meeting after the colectomy procedure/ostomy bag was required by R[redacted] 4. R[redacted] does not have the capacity to provide self-care for [redacted] 5. A family friend intermittently assists with the ostomy bag care, but facility staff does it when the family friend cannot assist.	A 020		
A 032	7 NMAC 8.2.32 Reporting of Incidents REPORTING OF INCIDENTS: A. The facility shall insure that all suspected cases or known incidents of resident abuse, neglect or exploitation are reported in accordance with 7.1.13 NMAC. (1) The facility shall also report any incident or unusual occurrence which has or could threaten the health, safety, or welfare of the residents and staff to the licensing authority complaint hotline within twenty-four (24) hours or by the next business day, if it is a weekend or a holiday. (2) The facility shall not delay a report to the complaint hotline while an internal investigation is	A 032		

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A 032	Continued From page 8 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: 7.8.2.32 A (1) B 7.1.13 INCIDENT REPORTING, INTAKE, PROCESSING AND TRAINING REQUIREMENTS Refer to 7.1.13.7 W. and 8 B. (2) W. "Reportable incident" means possible abuse, neglect, exploitation, injuries of unknown origin and other events including but not limited to falls which cause injury, unexpected death, elopement, medication error which causes or is likely to cause harm, failure to follow a doctor's order or an ISP or any other incident which may evidence abuse, neglect, or exploitation.	A 032		

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A 032	Continued From page 9 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. Based on record review and interview, the facility failed to ensure for [redacted] residents whose incident reports were reviewed for compliance that the facility: 1. Reported incidents of possible abuse, neglect, exploitation, or unusual occurrences that have threatened or could threaten the health, safety, or welfare of the residents and staff to the Licensing Authority within twenty-four (24) hours or by the next business day if it is a weekend or a holiday. 2. Conducted an internal investigation and submitted an investigation follow-up report to the Licensing Authority within five (5) business days from the date an incident occurred. These deficient practices could likely result in the residents being at risk of harm, injury, or death if	A 032	7.1.13 Incident Reporting, Intake, Processing and Training Requirements Administrator has knowledge of reporting procedures. When an incident occurs Administrator will report within 24 hours or as soon as Administrator is knowledgeable of the incident. A 5 day Follow up report will be submitted to the Department of Health regarding the follow up care and plan for prevention of future incidents. Staff will receive the required Incident reporting training and sign off that it was completed. by [redacted] 2024	

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A 032	Continued From page 10 incidents occur and there is no oversight by the Licensing Authority. The findings are: R #2 A. Record review of [redacted]/23 at 11:30 am internal Incident Report (IR) revealed: 1. As R[redacted] made[redacted] way to the toilet,[redacted] fell and hit[redacted] head on the chest dresser, causing a bleeding wound. The fall was not witnessed by anyone. 2. R[redacted] head was examined and bandaged by the hospice nurse to stop the bleeding. B. On [redacted]/24 at 7:40 am, during an interview with the Administrator, she confirmed that the facility failed to: 1. Report the [redacted]23 at 11:30 am incident involving R[redacted] to the Licensing Authority (LA) within 24 hours or the next business day. 2. Submit a five-day follow up investigative report to the LA. R[redacted] C. Record review of complaint intake #[redacted] showed: 1. On [redacted]/24, it was reported by the Power of Attorney (POA) of R[redacted] that[redacted] (R[redacted] was roughly handled by DCS[redacted] 2. R[redacted] presented with [redacted] 3. X-rays taken by the field nurse (an outside agency nurse) revealed[redacted] were present in the arm. D. Record review of [redacted]/24 at 10:00 am internal IR revealed:	A 032		

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A 032	Continued From page 11 1. R[redacted] had a bruising injury when sitting on the shower chair. 2. Treatment administered was ointment. 3. Injury occurred when a Direct Care Staff (DCS) was giving R[redacted] a shower. E. Record review of the Administrator's Witness Statement dated [redacted]/24 at 12:37 pm revealed: 1. On [redacted]/24, DCS [redacted] gave R[redacted] a shower and afterward, [redacted] complained that [redacted] arm hurt. 2. R[redacted] told the Administrator that DCS #4 lifted her (R [redacted] arm too high and kept the arm up. 3. On [redacted]/24, the Administrator contacted the Power of Attorney (POA)/Daughter to let her know that R[redacted] was in pain and the POA had a field nurse x-ray[redacted] at the facility. 4. The x-ray taken by the field nurse showed a hairline fracture and dislocation of[redacted] shoulder. 5. R[redacted] POA flew in from out of state, so they took R[redacted] to the Emergency Room (ER) and they confirmed the fracture. 6. The Administrator fired DCS #4 because she was "inappropriate towards" R[redacted] F. On [redacted]/24 at 12:37 pm, during an interview with the Administrator, the following was confirmed: 1. DCS #4 fractured R[redacted] arm when [redacted] (DCS #4) was giving R[redacted] shower. 2. A portable X-Ray was taken of R[redacted] arm the day after the incident, and it confirmed that the arm was fractured. 3. The Administrator fired DCS #4 after the fracture on R[redacted] arm was confirmed on [redacted]/24). 4. The Administrator failed to report the incident to the Licensing Authority (LA) within 24 hours or the next business day.	A 032		

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A 032	Continued From page 12 5. The Administrator failed to submit a five-day follow up investigative report to the LA.	A 032		