STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	4048	A. BUILDING: _____ B. WING _____	C 07/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEEHIVE HOMES OF BOSQUE FARMS #2	1935-B BOSQUE FARMS BLVD BOSQUE FARMS, NM 87068

(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 Full-Onsite/Complaint survey completed on [redacted]/23 for the state requirements of 7 NMAC 8.2, Regulations for Assisted Living Facilities for Adults. Census (14) Complaint Intake [redacted] was investigated with deficiencies cited. Abbreviations: lb - Pound fl oz - Fluid Ounce oz - Ounce gal - Gallon ML - Milliliter USP - United States Pharmacopeia MG - Milligrams	A 000		
A 016	7 NMAC 8.2.16 Staff Qualifications STAFF QUALIFICATIONS: A facility shall employ staff with the following qualifications. A. Administrator, director, operator: an assisted living facility shall be supervised by a full-time administrator. Multiple facilities that are located within a forty (40) mile radius may have one full-time administrator. The administrator shall: (1) be at least twenty-one (21) years of age; (2) have a high school diploma or its equivalent; (3) comply with the requirements of the New Mexico Caregivers Criminal History Screening Act, 7.1.9 NMAC; (4) complete a state approved certification program for assisted living administrators; (5) be able to communicate with the residents in the language spoken by the majority of the residents;	A 016		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Kathy Holmes | TITLE: Owner/Asst Admin. | (X6) DATE: 9/4/23

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A 016	Continued From page 1	A 016		

(6) not work while under the influence of alcohol or illegal drugs;
(7) have evidence of education and experience to prove the ability to administer, direct and operate an assisted living facility; the evidence of education and experience shall be directly related to the services that are provided at the facility;
(8) provide three (3) notarized letters of reference from persons unrelated to the applicant; and
(9) comply with the pre-employment requirements pursuant to the Employee Abuse Registry, 7.1.12 NMAC.
B. Direct care staff:
(1) shall be at least eighteen (18) years of age;
(2) shall have adequate education, relevant training, or experience to provide for the needs of the residents;
(3) shall comply with the pre-employment requirements pursuant to the Employee Abuse Registry, 7.1.12 NMAC; and
(4) shall comply with the current requirements of reporting and investigating incidents pursuant to Incident Reporting, Intake Processing and Training Requirements, 7.1.13 NMAC;
(5) if a facility provides transportation for residents, the employees of the facility who drive vehicles and transport residents shall have copies of the following documents on file at the facility:
(a) a valid New Mexico driver ' s license with the appropriate classification for the vehicle that is used to transport residents;
(b) documentation of training in transportation safety for the elderly and disabled, including safe vehicle operation;
(c) proof of insurance; and
(d) documentation of a clean driving record;
(6) any person who provides direct care who is not employed by an agency that is covered by the

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A 016	Continued From page 2 requirements of the Caregivers Criminal History Screening Requirements, 7.1.9 NMAC, shall provide current (within the last 6 months) proof of the caregivers criminal history screening to the facility; the facility shall maintain and have proof of such screening readily available; and (7) employers shall comply with the requirements of the Caregivers Criminal History Screening Requirements, 7.1.9 NMAC. [7.8.2.16 NMAC - Rp, 7.8.2.16 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.16 B (2) Based on record review and interview, the facility failed to ensure that the Direct Care Staff (DCS) received adequate education and specialized staff training for a Hoyer lift (a mobile floor lift system that is used to lift, suspend and transfer a medically dependent person). This deficient practice could likely result in the [redacted] residents who require the use of a Hoyer lift for transfers, identified on the resident census provided by the Administrator on [redacted]/23, to be at risk if staff accidentally drop the residents or position them incorrectly, while using a Hoyer lift during a transfer, because they are not properly trained to use a Hoyer lift. The findings are: A. Record review of DCS #2's (hire date 06/17/17) staff file revealed, no documentation of training related to the use of a Hoyer lift.	A 016	A016- (A thru G), DCS will be trained by the Hospice nurse or House manager on how to use a Hoyer lift. Documentation of training will be included in DCS personnel binders. All current & new caregivers will be trained & documentation provided, as indicated.	6-29-2023

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A 016	Continued From page 3 B. Record review of DCS #4's (hire date [redacted]/20) staff file revealed, no documentation of training related to the use of a Hoyer lift. C. Record review of DCS #6's (hire date [redacted]/22) staff file revealed, no documentation of training related to the use of a Hoyer lift. D. On [redacted]/23 at 10:56 am, during an interview with DCS #2, she confirmed, she has not received training on how to use the Hoyer lift, but has previous experience from another facility. E. On [redacted]/23 at 11:30 am, during an interview with the House Manager, she confirmed that she has had nurses in the past come to the facility to train DCS on how to use the Hoyer lifts, but those trainings were not documented. F. On [redacted]/23 at 3:30 pm, during an interview with DCS #4, she confirmed she was not trained on how to use the Hoyer lifts. G. On [redacted]23 at 3:27 pm, during an interview with DCS #6, she confirmed she was not trained on how to use the Hoyer lifts.	A 016		
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	A 017		

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A 017	Continued From page 4 least twelve (12) hours annually, the orientation, training and proof of competency shall include: (1) fire safety and evacuation training; (2) first aid; (3) safe food handling practices (for persons involved in food preparation), to include: (a) instructions in proper storage; (b) preparation and serving of food; (c) safety in food handling; (d) appropriate personal hygiene; and (e) infectious and communicable disease control; (4) confidentiality of records and resident information; (5) infection control; (6) resident rights; (7) reporting requirements for abuse, neglect or exploitation in accordance with 7.1.13 NMAC; (8) smoking policy for staff, residents and visitors; (9) methods to provide quality resident care; (10) emergency procedures; (11) medication assistance, including the certificate of training for staff that assist with 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 (1-12) Based on record review and interview, the facility failed to ensure that the Direct Care Staff (DCS)	A 017		

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A 017	Continued From page 5	A 017		

received twelve (12) hours of orientation/annual training in the required topics.

This deficient practice could likely result in the [redacted] residents identified on the census provided by the Administrator on [redacted]23, to be at risk for harm, illness, or injury, if the DCS providing care have not received all required orientation/annual trainings and do not know how to properly care for residents. The findings are:

DCS #1

A. Record review of DCS #1's (date of hire: [redacted]/18) annual training records, revealed no documentation showing that the following required trainings were received in 2019, 2020, 2021 and 2022:
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
e. Infectious and communicable disease control
4. Confidentiality of records and resident information
5. Infection control
6. Resident rights
7. Reporting requirements for abuse, neglect or exploitation in accordance with 7.1.13 NMAC
8. Smoking policy for staff, residents and visitors
9. Methods to provide quality resident care.
10. Emergency procedures
11. Medication assistance, including the certificate of training for staff that assist with medication delivery.
12. The proper way to implement a resident ISP

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A 017	Continued From page 6 (Individual Service Plan) for staff that assist with ISPs. B. On [redacted]/23 at 4:00 pm, during an interview, DCS #1 confirmed that she could not remember receiving the above required annual trainings for the years of 2019, 2020, 2021 and 2022. DCS #2 C. Record review of DCS #2's (date of hire: [redacted]/17) annual training records, revealed no documentation showing that the following trainings were received in 2018, 2019, 2020, 2021 and 2022: 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 e. Infectious and communicable disease control 4. Confidentiality of records and resident information 5. Infection control 6. Resident rights 7. Reporting requirements for abuse, neglect or exploitation in accordance with 7.1.13 NMAC 8. Smoking policy for staff, residents and visitors 9. Methods to provide quality resident care. 10. Emergency procedures 11. Medication assistance, including the certificate of training for staff that assist with medication delivery. 12. The proper way to implement a resident ISP for staff that assist with ISPs. D. On [redacted]/23 at 11:50 am, during an interview,	A 017		

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A 017	Continued From page 7 DCS #2 confirmed that she could not remember receiving the above required annual trainings for the years of 2018, 2019, 2020, 2021 and 2022. DCS #4: E. Record review of DCS #4's (date of hire: [redacted]/20) annual training records, revealed there was no documentation showing that the following trainings were received in 2021 and in 2022: 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 e. Infectious and communicable disease control 4. Confidentiality of records and resident information 5. Infection control 6. Resident rights 7. Reporting requirements for abuse, neglect or exploitation in accordance with 7.1.13 NMAC 8. Smoking policy for staff, residents and visitors 9. Methods to provide quality resident care. 10. Emergency procedures 11. Medication assistance, including the certificate of training for staff that assist with medication delivery. 12. The proper way to implement a resident ISP for staff that assist with ISPs. F. On [redacted]/23 at 3:30 pm, during an interview, DCS #4 confirmed that: 1. There was no orientation training provided for new staff. 2. That she has not received any of the required annual trainings in 2020, 2021, and 2022.	A 017	A017- A thru G, A spread sheet is now in place to record each employee 12 hours of Orientation Training and 6 hours of Palliative/Hospice Training. In the future, the House Manager will keep documents for monthly trainings for all employees and update training log. Please see attachment.	7-19-2023

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A 017	Continued From page 8 G. On [redacted]/23 at 2:30 pm, during an interview with the House Manager, she confirmed that DCS #s 1, 2, & 4 did not receive the required orientation/annual trainings listed above.	A 017		
A 020	7 NMAC 8.2.20 Admissions and Discharge ADMISSIONS AND DISCHARGE: The facility shall complete an admission agreement for each resident. The administrator of the facility or a designee responsible for admission decisions shall meet with the resident or the resident ' s surrogate decision maker prior to admission. No resident shall be admitted who is below the age of eighteen (18) or for whom the facility is unable to provide appropriate care. A. Admission agreement. The admission agreement shall include the following information: (1) the parties to the agreement; (2) the program narrative; (3) the facility's rules; (4) the cost of services and the method of payment; (5) the refund provision in case of death, transfer, voluntary or involuntary discharge; (6) information to formulate advance directives; (7) a written description of the legal rights of the residents translated into another language, if necessary; (8) the facility's staffing ratio; (9) written authorization for staff to assist with medications; (10) notification of rights and responsibilities pursuant to the Incident Reporting Intake, Processing and Training Requirements, 7.1.13 NMAC; (11) the facility ' s bed hold policy; and (12) the admission agreement may be terminated	A 020		

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A 020	Continued From page 9 if an appropriate placement is found for the resident, under the following circumstances: (a) there shall be a fifteen (15) day written notice of termination given to the resident or his or her surrogate decision maker, unless the resident requests the termination; (b) the resident has failed to pay for a stay at the facility as defined in the admission agreement; (c) the facility ceases to operate or is no longer able to provide services to the resident; (d) the resident ' s health has improved sufficiently and therefore no longer requires the services of the facility; (e) termination without prior notice is permitted in emergency situations for the following reasons: (i) the transfer or discharge is necessary for the resident's safety and welfare; (ii) the resident's needs cannot safely be met in the facility; or (iii) the safety and health of other residents and staff in the facility are endangered; (13) the facility shall provide a thirty (30) day written notice to residents regarding any changes in the cost or the material services provided; a new or amended admission agreement must be executed whenever services, costs or other material terms are changed; and (14) facilities representing their services as " specialized " must disclose evidence of staff specialty training to prospective residents. B. Restrictions in admission. The facility shall not admit or retain individuals that require twenty-four (24) hour continuous nursing care, refer to Subsection U of 7.8.2.7 NMAC Definitions. This rule does not apply to hospice residents who 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:	A 020		

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A 020	Continued From page 10 (1) ventilator dependency; (2) pressure sores and decubitus ulcers (stage III or IV); (3) intravenous therapy or injections; (4) any condition requiring either physical or chemical restraints; (5) nasogastric tubes; (6) tracheostomy care; (7) residents that present an imminent physical threat or danger to self or others; (8) residents whose psychological or physical condition has declined and placement in the current facility is no longer appropriate as determined by the PCP; (9) residents with a diagnosis that requires isolation techniques; (10) residents that require the use of a Hoyer lift; and (11) ostomy (unless resident is able to provide self care). C. Exceptions to admission, readmission and retention. If a resident requires a greater degree of care than the facility would normally provide or is permitted to provide and the resident wishes to be re-admitted or remain in the facility and the facility wishes to re-admit or retain the resident. The facility shall comply with the following requirements. (1) Convene a team, comprised of: (a) the facility administrator and a facility health care professional if desired; (b) the resident or resident ' s surrogate decision maker; and (c) the hospice or home health clinician. (2) The team shall jointly determine if the resident 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	A 020		

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A 020	Continued From page 11 resident's record and shall: (a) be based upon an individual service plan (ISP) which identifies the resident's specific needs and addresses the manner that such needs will be met; (b) ensure that if the facility is licensed for more than eight (8) residents and does not have complete fire sprinkler coverage, the facility shall maintain an evacuation rating score of prompt as determined by the fire safety equivalency system (FSES); (c) evaluate and outline how meeting the specific needs of the resident will impact the staff and the other residents; and (d) include an independent advocate such as a certified ombudsman if requested by the resident, the family or the facility. (3) The team recommendation shall be maintained on site in the resident ' s file. (4) When a resident is discharged, the facility shall record where the resident was discharged to and what medications were released with the resident. D. Coordination of care. (1) Assisted living facilities shall have evidence of care coordination on an ISP for all services that are provided in the facility by an outside health care provider, such as hospice or home health providers. (2) Residents shall be given a list of providers, including hospice and home health if applicable, and have the right to choose their provider. If applicable, the referring party shall disclose any ownership interest in a recommended or listed provider. [7.8.2.20 NMAC - Rp, 7.8.2.19 NMAC & 7.8.2.20 NMAC, 01/15/2010]	A 020		

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A 020	Continued From page 12 This REQUIREMENT is not met as evidenced by: 7.8.2.20 A (5) B (10) C (1) (a-c) (2) (a & c) (3) D (1) SB0335 - 2013 AN ACT RELATING TO HEALTH CARE; REQUIRING CONTRACTS FOR ASSISTED LIVING FACILITIES TO CONTAIN A REFUND POLICY UPON TERMINATION OF A CONTRACT DUE TO THE DEATH OF THE RESIDENT; PROVIDING FOR STORAGE OF A RESIDENT'S BELONGINGS; DECLARING AN EMERGENCY. BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF NEW MEXICO: SECTION 1. A new section of the Public Health Act is enacted to read: "ASSISTED LIVING FACILITIES CONTRACTS--LIMIT ON CHARGES AFTER RESIDENT DEATH.-- A. The contract for each resident of an assisted living facility shall include a refund policy to be implemented at the time of a resident's death. The refund policy shall provide that the resident's estate or responsible party is entitled to a prorated refund based on the calculated daily rate for any unused portion of payment beyond the termination date after all charges have been paid to the licensee. For the purpose of this section, the termination date shall be the date the unit is vacated by the resident due to the resident's death and cleared of all personal belongings. B. If a resident's belongings are not removed within one week of the resident's death and the amount of belongings does not preclude renting the unit, the facility may clear the unit and	A 020		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEEHIVE HOMES OF BOSQUE FARMS #2	1935-B BOSQUE FARMS BLVD BOSQUE FARMS, NM 87068

(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
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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, observation, and interview, the facility failed to ensure that:

1. The resident Admission/Discharge Agreements included a refund upon death policy in compliance with NMAC 7.8.2.20, (SB) 0335 - 2013.

2. An exception team meeting was convened for residents requiring the use of a Hoyer Lift (medical devices that are used to transfer patients with limited mobility from one location to another) that is a restriction to admission.

3. The team included the facility Administrator and Health Care Professional (if desired), the Resident/Resident's Surrogate Decision Maker, and the Hospice/Home Health Care Clinician if applicable.

4. The team jointly agreed that the resident should be admitted to the facility and there was written documentation of the agreement signed and date by all the members of the team and:

a. Was based upon an Individual Service plan (ISP) which identified the resident's specific

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needs and addressed the manner that such needs would be met.
b. The team evaluated and outlined how meeting the specific needs of the residents would have an impact on the staff and the other residents living there.

These deficient practices could likely result in the [redacted] residents identified on the census provided by the Administrator on [redacted]/23, to be at risk if:
1. The resident's estate/legal representative suffering financial hardship by not receiving the refund that is due upon the resident's death or being aware of additional charges that may be owed.
2. There were not enough staff to meet the needs of the residents who require the use of a Hoyer Lift and all the other residents.
3. The staff neglected other residents due to extra time and extra staff required to care for the higher level of specialized care necessary for the residents requiring Hoyer lift transfers.
4. A team meeting was not convened to determination that the needs of the residents who require the use of a Hoyer lift can be met by the facility.
5. There was no coordination of care with outside agencies identified on the ISP to ensure the residents needs are being met and the DCS know what services they need to provide and what services will be provided by the agency staff.

The findings are:

The findings related to the Refund Upon Death policy

A. Record review of R #1's Admissions/Discharge Agreement dated [redacted]22, revealed that it did

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A 020	Continued From page 15 not include a refund provision in case of death that was in compliance with NMAC 7.8.2.20, (SB) 0335 - 2013. B. Record review of R #2's Admissions/Discharge Agreement dated [redacted]/23, revealed that it did not include a refund provision in case of death that was in compliance with NMAC 7.8.2.20, (SB) 0335 - 2013. C. Record review of R #3's Admission/Discharge Agreement dated [redacted]/22, revealed that it did not include a refund provision in case of death that was in compliance with NMAC 7.8.2.20, (SB) 0335 - 2013. D. Record review of R #4's Admission/Discharge Agreement dated [redacted]/19, revealed that it did not include a refund provision in case of death that was in compliance with NMAC 7.8.2.20, (SB) 0335 - 2013. E. Record review of R #5's Admission/Discharge Agreement, dated [redacted]/23, discharged [redacted]23), revealed that it did not include a refund provision in case of death that was in compliance with NMAC 7.8.2.20, (SB) 0335 - 2013. F. On [redacted]/23 at 2:30 pm, during an interview with the House Manager, she confirmed that R #s 1-5 Admission/Discharge Agreements did not include a refund provision in case of death that was in compliance with NMAC 7.8.2.20, (SB) 0335 - 2013. Findings related to Hoyer lifts. R #1 G. Record review of R #1's (admission date	A 020	A020- A thru F, The resident refund policy has been up-dated to include the words "Daily Rate" as required. House manager is responsible for completing and ensuring ongoing compliance. Please see attachment.	8-30-2023

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A 020	Continued From page 16 [redacted]/22) resident file revealed the following: 1. A Hospice and Home Heath Verbal Care Conference form dated [redacted]/23 [redacted]) revealed that a team meeting was held and the need for R #1 to have a Hoyer lift was noted. 2. There was no documentation of an Individual Service Plan (ISP) or Evaluation identifying being updated to include the resident's specific need of requiring the use of a Hoyer lift for all transfers that included: a. How R #1's specific needs would be met. b. How meeting the specific needs of R #1 would impact on the care and safety of other residents living there. c. The Direct Care Staff (DCS) ability to provide care and evacuate all residents if a fire or other incident occurred that required evacuation. H. Record review of R #1's Evaluation/Assessments ([redacted]/23) revealed it was not updated to reflect the resident's specific need for a Hoyer lift for transfer assistance. I. Record review of R #1's ISP (dated [redacted]/23) revealed it was not updated to reflect the resident's specific need for a Hoyer lift for transfer assistance or the coordination of care with the [redacted] Agency. J. On [redacted]/23 at 10:56 am, during an interview with DCS #2, she confirmed for R #1: 1. That the lift was not a sit to stand assist, but an actual Hoyer lift to fully lift R #1's entire body during transfers. 2. DCS #2 demonstrated how she sits R #1 on the sling and will then attach it to the hooks on the lift, to then lift R #1 off of[redacted] chair or bed.	A 020	A 020- G thru T, Hoyer lifts will be documented in all of the resident's ISP's and evaluations for each of our resident specific needs. We will continue to train DCS how to safely transfer residents by holding monthly trainings by the House manager. DCS will be trained how to evacuate all bedridden residents safely. House manager and House Nurse are responsible for completing and ensuring compliance.	8-30-2023

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A 020	Continued From page 17 3. R #s 1, 4 and 6 use a Hoyer lift at this time. 4. She (DCS #2) does not know where the Hoyer lift manual is at this time R #4 K. On [redacted] 23 at 9:22 am, during an observation of R #4's [redacted] a Hoyer lift was observed next to the resident's bed and a Hoyer lift harness was observed in the resident's [redacted]. L. On [redacted] 23 at 9:27 am, during an interview with DCS #4, she confirmed [redacted] doesn't use the Hoyer lift to transfer R #4 because [redacted] is able to do it on her own, but other DCS use it to transfer R #4 to and from the bed, and to and from her chair. M. Record review of R #4's (admission date [redacted]/19) resident file revealed: 1. A home care letter (not dated) confirming R #4 was admitted to [redacted] on [redacted] 20 and was approved to use a Hoyer lift by [redacted], family, [redacted] medical director, and facility staff (no names provided). 2. No documentation of the following: a. That an Exception Team Meeting was held upon the approval of the use of a Hoyer lift on [redacted] 20. b. An ISP or evaluation identifying the resident's specific need of requiring the use of a Hoyer lift for all transfers including: i. How R #4's specific needs would be met. ii. How meeting the specific needs of R #4 would impact on the care and safety of other residents living there. iii. The Direct Care Staff (DCS) ability to provide care and evacuate all residents if a fire or other incident occurred that required evacuation.	A 020	A020-R #4, K thru P. Updates will be documented in all of our ISP's and evaluations when a Hoyer lift is approved by Hospice. Specific needs will be addressed per each of our residents. This will also include a plan for evacuations, if an emergency occurs. ISP's and evaluations will include how to transfer residents in a safe manner by holding monthly meetings and trainings for our staff.	8-30-2023

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A 020	Continued From page 18 N. Record review of R #4's Physician's Order dated [redacted]23, revealed an order for the use of a Hoyer lift as needed for all transfers. O. Record review of R #4's resident file revealed no documentation that R #4's evaluations were updated to reflect the resident's specific need for a Hoyer lift for transfer assistance and change of care on [redacted]20. P. Record review of R #4's ISP dated [redacted]/23, revealed no documentation was provided to show that the ISP included: 1. The resident's specific need for a Hoyer lift for transfers that was ordered on [redacted]/20. 2. Coordination of care with the [redacted] agency. R #6 Q. Record review of R #6's (admission date [redacted]/19) resident file revealed: 1. A[redacted] and home heath verbal care conference dated [redacted]/21, addressing the use of a Hoyer lift if needed. 2. No documentation of an ISP or evaluation identifying the resident's specific need of requiring the use of a Hoyer lift for all transfers including: a. How R #6's specific needs would be met. b. How meeting the specific needs of R #6 would impact on the care and safety of other residents living there. c. The Direct Care Staff (DCS) ability to provide care and evacuate all residents if a fire or other incident occurred that required evacuation. R. Record request for R #6's resident evaluations revealed, there was no documentation provided to show that the evaluation was updated to reflect the resident's specific need for a Hoyer lift for transfer assistance.	A 020	A020- R #6, Q thru T. Updates will be documented in all of our ISP's and evaluations when a Hoyer lift is approved by Hospice. Specific needs will be addressed per each of our residents. This will also include a plan for evacuations If an emergency occurs. ISP"S and evaluations will include how to transfer residents in a safe manner by holding monthly meetings and training for all of our staff.	8-30-2023

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A 020	Continued From page 19 S. Record review of R#6's ISP dated [redacted]/23 revealed, it was not updated to reflect the resident's specific need for a Hoyer lift for transfer assistance or the coordination of care with the [redacted] Agency. T. On [redacted]23, during an interview with the House Manager, she confirmed the findings listed above for R #'s 1, 4 and 6.	A 020		
A 021	7 NMAC 8.2.21 Resident Records RESIDENT RECORDS: A. Record contents. A record for each resident shall be maintained in accordance with the specific requirements of this section. Entries in each resident's record shall be legible, dated and authenticated by the signature of the person making the entry. Resident records shall be readily available on site and organized utilizing a table of contents. Each resident record shall include: (1) the admission agreement records, as set forth in 7.8.2.20 NMAC; (2) the resident evaluation form, that is to be completed within fifteen (15) days prior to admission and updated at a minimum of every six (6) months; (3) the current ISP, that is to be completed within ten (10) calendar days of admission and updated at a minimum of every six (6) months; (4) the physical examination report; the physical examination report shall have been completed within the past six (6) months, by a primary care physician, a nurse practitioner or a physician ' s assistant and shall be on file in the resident ' s record within ten (10) days of admission; (5) personal and demographic information for the	A 021		

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A 021	Continued From page 20 resident, to include: (a) current names, addresses, relationship and phone numbers of family members, or surrogate decision makers updated as necessary; (b) resident's name; (c) age; (d) recent photograph; (e) marital status; (f) date of birth; (g) sex; (h) address prior to admission; (i) religion (optional); (j) personal physician; (k) dentist; (l) social history; (m) surrogate decision maker or other emergency contact person; (n) language spoken and understood; (o) legal documentation relevant to commitment or guardianship status; (p) current medications list; and (q) required diet; (6) unless included in the admission agreement, a separate written agreement between the facility and the resident relating to the resident's funds, in accordance with the facility's policy and procedures; (7) entries by direct care staff, appropriate health care professionals and others authorized to care for the resident; entries shall be dated and signed by the person making the entry and shall include significant information related to the ISP; (8) entries that provide a written account of all accidents, injuries, illnesses, medical and dental appointments, any problems or improvements observed in the resident, any condition that would indicate a need for alternative placement or medical attention and entries reflecting appropriate follow-up; the maintenance of such	A 021		

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A 021	Continued From page 21 written documentation in the resident record may be by copy of an incident or accident report, if the original incident or accident report is maintained elsewhere by the facility; (9) the medication assistance record (MAR); the MAR is the document that details the resident's medication; the MAR shall include all of the information pursuant to Subsection G of 7.8.2.35 NMAC of this rule; (10) progress notes completed by any contract agency (e.g., hospice, home health); the progress notes shall include the date, time and type of health services provided; (11) copies of all completed and signed transfer forms from the accepting facility when a resident is transferred to a hospital or another health care facility and when the resident is transferred back to the facility; and (12) upon the death or transfer of a resident, documentation of the disposition of the resident's personal effects and money or valuables that are deposited with the assisted living facility. B. Resident records maintenance. (1) Current resident records shall be maintained on-site and stored in an organized, accessible and permanent manner. (2) The facility shall establish a policy to maintain and ensure the confidentiality of resident records, including the authorized release of information from the resident records. (3) Non-current resident records shall be maintained by the facility against loss, destruction and unauthorized use for a period of not less than five (5) years from the date of discharge and readily available within twenty-four (24) hours of request. (4) There shall be a policy and procedure in place for record retention in the event of facility closure. (5) Failure to follow facility policies is grounds for	A 021		

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A 021	Continued From page 22 sanctions. [7.8.2.21 NMAC - Rp, 7.8.2.22 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.21 A (8) Based on record request and interview the facility failed to ensure for [redacted] residents whose facility records were reviewed for compliance had entries (documentation) that provide a written account of all accidents, injuries, any problems or improvements observed in the resident, any condition that would indicate a need for alternative placement or medical attention and entries reflecting appropriate follow-up. This deficient practice could likely affect the health, safety, and welfare of the residents if the facility and Direct Care Staff (DCS) are not aware of any accidents, injuries, or problems that would indicate a need for alternative placement or medical attention. The findings are: The findings are: A. On [redacted]/23 at 4:00 pm, during an interview with DCS #6, she confirmed that R #2 started to decline shortly after moving into the facility (no exact dates recorded) and was not eating as much as [redacted] when [redacted] first moved in. B. On [redacted]/23 at 11:30 am, during an interview with the House Manager, she confirmed that R #2 became weaker shortly after moving into the facility (no exact dates recorded) and was not able to feed [redacted] much and required more	A 021		

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A 021	Continued From page 23 assistance with mobility and standby by assistance. C. On [redacted]23 at 11:50 am, during an interview with DCS #2, she confirmed that R #2 would sometimes choke at the table during meals and would sometimes have a small cough. D. On [redacted]3 at 3:30 pm, during an interview with DCS #4, she confirmed: 1. When R #2 first moved into the facility, [redacted] was able to move around, but started to decline and needed assistance going to the restroom (no exact dates recorded). 2. R #2 did not like being soiled and went to the bathroom [redacted] own and fell (unknown dates). 3. R #2 had two (2) falls in the facility while trying to go the restroom on [redacted], and one (1) fall while trying to get up [redacted] bed on [redacted] own. E. On [redacted]/23 at 3:27 pm, during an interview with DCS #6, she confirmed that notes regarding R #2 and any changes in [redacted] condition would have been documented in shift notes that are kept in the medication cart. F. Record request for R #2's Shift/Care notes revealed no documentation on any written entries showing the decline in R #2's health. G. On [redacted]/23 at 8:22 am, during an interview with the House Manger, she confirmed, that there was no documentation of written entries to show the residents decline and to show documentation of the falls.	A 021	A 0121- A thru G, All DCS are trained in documenting all accidents, injuries, or any changes in residents condition. House manager will monitor to ensure ongoing compliance.	08/30/2023
A 022	7 NMAC 8.2.22 Facility Reports, Records, Rules, Policies	A 022		

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A 022	Continued From page 24 FACILITY REPORTS, RECORDS, RULES, POLICIES AND PROCEDURES: A. Reports and records. Each facility shall keep the following reports, records, policies and procedures on file at the facility and make them available for review upon request by the licensing authority, residents, potential residents or their surrogate decision makers: (1) fire inspection report; (2) zoning approval; (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	A 022		

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A 022	Continued From page 25	A 022		

evacuation, persons to be notified, emergency equipment, evacuation routes, refuge areas and the responsibilities of personnel during emergencies; plans shall also included a list of transportation resources that are immediately available to transport the residents to another location in an emergency; the emergency preparedness plan shall address two types of emergencies:
(a) an emergency that affects just the facility; and
(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

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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 022	Continued From page 26 resident ' s rights and shall include the following: (1) resident use of tobacco and alcohol; (2) resident use of facility telephone or personal cell phone; (3) resident use of television, radio, stereo and cd; (4) the use and safekeeping of residents ' personal property; (5) meal availability and times; (6) resident use of common areas; (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;	A 022		

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A 022	Continued From page 27 (9) staff and resident fire and safety training; (10) smoking policy for staff, residents and visitors; (11) the facility's bed hold policy; (12) admission agreement; (13) admission records; (14) resident records including maintenance and record retention if the facility closes; (15) program narrative; (16) resident's rights with regard to making health care decisions and the formulation of advance directives; (17) personnel policies; (18) identifying and safeguarding resident possessions; (19) securing medical assistance if a resident's own physician is not available; (20) staff training appropriate to staff responsibilities; (21) staff training for employees who provide assistance to residents with boarding or alighting from motor vehicles and safe operation of motor vehicles to transport residents; (22) witnessed destruction of unused, outdated or recalled medication by the facility administrator with the consulting pharmacist present; and (23) mealtimes, daily snacks, menus, special diets, resident ' s personal preference for eating alone or in the dining room setting. [7.8.2.22 NMAC - Rp, 7.8.2.23 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.22 A (10) (a-b) D (2 & 4)	A 022		

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A 022	Continued From page 28 Based on record review and interview, the facility failed to ensure, that there: 1. Were written policy and procedure plans for emergencies that affect the facility and region-wide emergencies and how the facility staff will remain informed of resident information in case of an emergency (evacuation). 2. Was a written policy for updating and consolidating resident records containing current physician or PCP (Primary Care Physician) orders, treatments and diet plans every six (6) months, or when a significant change has occurred. 3. Was a method of staying informed when residents are away from the facility (sign-out sheets, names, and contact information for family and friends). The findings are: These deficient practices could likely negatively affect the health and safety of the [redacted] residents listed on the resident census, provided by the House Manager on [redacted]/23, if: 1. Staff, residents, and families do not know what to do or where to go if an emergency or disaster were to occur and the staff do not have access to pertinent resident information regarding contacts and health needs. 2. The resident's physical health is not being monitored on a regular basis by their assigned physicians in order to address their overall care and needs, especially if the resident's health changes. 3. Residents were to leave the facility and the staff do not know who they are with, when they will return, or who to reach out to if the resident does not return to the facility. The findings are: A. Record review of the facility's policy and	A 022		

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A 022	Continued From page 29 procedure documents revealed no written Emergency Disaster Evacuation Plan in place for both a facility only and/or a region/area-wide emergency that covered medical emergencies, power failure, fire or natural disaster. No documentation that included: 1. Evacuation procedure 2. Persons to be notified 3. Emergency equipment 4. Evacuation routes 5. Refuge areas 6. Responsibilities of personnel during emergencies 7. Transportation resources. B. Record Review of the facility's Policy and Procedure manual provided by the House Manager revealed no documentation of the following: 1. Policy and procedure for updating and consolidating the resident's current physician or PCP orders, treatments, and diet plans every six (6) months or when a significant change occurs, such as a hospital admission. 2. 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.) C. On [redacted]/23 at 2:30 pm, during an interview with the House Manager, she confirmed that the facility did not have written emergency evacuation plans in place for both a facility only and/or a region/area-wide emergencies and the policies listed above in were missing from the Policy and Procedure manual.	A 022	A 022-A, B & C, The Policy and Procedure Manual is in the medication room for all to review as needed. The Emergency Disaster Manual is included in the Policies and Procedures manual. All DCS are required to sign an acknowledgement sheet that they have reviewed the P&P Manual. Manager will monitor monthly to ensure ongoing compliance. Please see attachments.	6-26-2023
A 025	7 NMAC 8.2.25 Resident Evaluation	A 025		

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A 025	Continued From page 30 RESIDENT EVALUATION: A. A resident evaluation shall be completed by an appropriate staff member within fifteen (15) days prior to admission to determine the level of assistance that is needed and if the level of services required by the resident can be met by the facility. B. The initial resident evaluation shall establish a baseline in the resident ' s functional status and thereafter assist with identifying resident changes. The resident evaluation shall be reviewed and updated at a minimum of every six (6) months or when there is a significant change in the resident ' s health status. C. The resident ' s evaluation shall be documented on a resident evaluation form and at a minimum include the following abilities, 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	A 025		

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A 025	Continued From page 31 medical needs such as hospice; and (17) safety needs/high risk behaviors; history of falls agitation, wandering, fire safety issues, etc. D. The resident evaluation shall include a history and physical examination and an evaluation report by a physician or a physician extender within six (6) months of admission. A resident shall have a medical evaluation by a physician or a physician extender at least annually. E. The resident evaluation shall be reviewed and if needed revised by a licensed practical nurse, registered nurse or physician extender at the time the individual service plan is reviewed, at a minimum of every six (6) months or when a significant change in health status occurs. [7.8.2.25 NMAC - Rp, 7.8.2.25 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.25 B C (10, 11, & 16) Based on record review and interview, the facility failed to ensure for [redacted] residents whose Evaluations were reviewed for compliance, that they: 1. Were reviewed and updated at a minimum of every six (6) months or when there is a significant change in the resident's health status. 2. Documented the following behaviors or status: a. Diagnosis b. Health conditions c. Special medical needs such as hospice and the use of a Hoyer lift (an assistive device that allows patients to be transferred by the use of electrical or hydraulic power).	A 025	A 025, Evaluations are done every 6 months. If there is no change in condition, no change is noted. If a change occurs, such as a hospital admission, POA's and their PCPs are contacted immediately. Documentation on resident's evaluations will start including diagnosis and health conditions. If a Hoyer lift is needed/ discussed, documentation will also be included in the evaluations and signed off by the House Nurse. Evaluations will be completed within 15 days prior to admission and again every 6 months as usual.	8-30-2023

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A 025	Continued From page 32 These deficient practices could likely result in the residents to be at risk of not getting the care and services needed if the Direct Care Staff (DCS) do not know what the residents' correct needs are. The findings are: R #1 A. Record review of R #1's (admission date: [redacted]/22) History and Physical dated [redacted], revealed that R #1 had the following diagnosis and conditions: [redacted] B. Record review of R #1's History and Physical dated[redacted]22, revealed that R #1 had a recent hospitalization for[redacted], had the conditions listed below, and the following home health services were determined medically necessary: 1.[redacted] 2. 3. 4. 5. 6.	A 025		

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A 025	Continued From page 33 8. [redacted] 9. Requires home health services due to [redacted]. C. Record review of R #1's Hospice and Home Health Verbal Care Conference form dated [redacted] revealed, R #1 was admitted to [redacted] and the use of a [redacted] was discussed. D. On [redacted]/23 at 11:11 am, the House Manager confirmed that R #1 was admitted to [redacted] on [redacted] and received an order for the use of a Hoyer lift. E. Record review of R #1's resident Evaluations dated [redacted] revealed: 1. The evaluations did not document the diagnosis, health conditions and special medical needs such as home health, physical therapy and occupational therapy as documented on the [redacted] 2. There is no documentation showing that the Evaluations were reviewed and updated when there is a significant change in the resident's health status, such as: a. Being admitted to [redacted]/23. b. Receiving the order for the use of a [redacted] R #2 F. Record review of R #2's (admission date: [redacted] History and Physical dated on [redacted] that indicated R #2 had a history of: 1. [redacted] 2. [redacted] 3. [redacted] 4. [redacted]	A 025	A 025-A thru E, Documentation on all of our resident's evaluations will start including diagnosis and health conditions. If a Hoyer lift is needed/ discussed, documentation will also be included in the evaluations at that time and signed off by the Nurse. Evaluations will be reviewed and updated when there is a significant change in the resident's health status. Evaluations will be completed within15 days prior to admission and again every 6 months as usual.	8-30-2023

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A 025	Continued From page 34 5. [redacted] 6. [redacted] 8. [redacted] 9. [redacted] 10. [redacted] G. Record review of R #2's resident Evaluation dated [redacted]/22, revealed, it did not address the diagnosis and health conditions as documented [redacted] 12/28/22. H. On [redacted]23 at 11:30 am, during an interview with the House Manager, she confirmed that resident Evaluation dated [redacted] did not reflect R #2's health conditions or diagnosis because [redacted] not have R #2's Physician packet at the time of completing the evaluation. R #4 I. Record review of R #4's (admission date: [redacted]19) [redacted] and Plan of Care meeting dated [redacted]/20, revealed R #4 had the following diagnosis and health conditions: 1. [redacted] 2. [redacted] 3. [redacted] 4. [redacted] J. Record review of a Physician's Referral Letter dated [redacted], revealed R #4 had the following diagnosis and health conditions:	A 025	A 025-F thru H, Documentation on resident's evaluations will start including diagnosis and health conditions. If a Hoyer lift is needed/ discussed, documentation will also be included in the evaluations and signed off by the Nurse. Evaluations will be reviewed and updated when there is a significant change in the resident's health status. Evaluations will be completed within 15 days prior to admission and again every 6 months as usual. A 025- I, Evaluations will include diagnosis and current health conditions of a resident. If a Hoyer lift is needed/ discussed, Hospice nurse will include it in the evaluation and house manager will update ISP. . Updates will be documented when there is a significant change in the resident's health status. Evaluations will be completed within 15 days prior to admission and again every 6 months as usual.	8-30-2023

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A 025	Continued From page 35 1. [redacted] 2. [redacted] 3. [redacted] 4. [redacted] 5. [redacted] 6. [redacted] 7. [redacted] 8. [redacted] K. Record review of R #4's resident Evaluations dated [redacted] revealed: 1. No documentation of the diagnosis and health conditions as documented on the [redacted], and/or the Physician Referral Letter dated [redacted] 2. There is no documentation showing that the evaluations were reviewed and updated when there is a significant change in the resident's health status, such as: a. Being admitted to [redacted] b. Receiving the order for the use of a [redacted] L. On [redacted]/23 at 2:00 pm, during an interview with the House Manager, she confirmed that for R #s 1, 2, and 4, that their resident Evaluations	A 025		

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A 025	Continued From page 36 did not reflect the diagnosis and health conditions listed on their physician assessments, and the evaluations did not reflect special medical needs such as hospice or the use of the Hoyer lifts. R #6 M. Record review of R #6's (admission date: [redacted]19) resident file revealed there was no documentation provided to show that the evaluation was completed within fifteen (15) days prior to admission and updated at a minimum of every six (6) months. N. On [redacted]/23 at 2:00 pm, during an interview with the House Manager, she confirmed there was no documentation of an evaluation being completed within fifteen (15) days prior to admission and updated at a minimum of every six (6) months for R #6.	A 025	A 025- M, N, Documentation on resident's evaluations will start including diagnosis and health conditions. If a Hoyer lift is needed/discussed, documentation will also be included in the evaluations and signed off by the Nurse. Evaluations will be completed within 15 days prior to admission. Individual service plan will be completed within 10 days of admission for each resident residing in the facility.	8-30-2023
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	A 026		

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A 026	Continued From page 37 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. [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 A (1 & 3) Based on record review and interview, the facility failed to ensure for [redacted] residents whose Individual Service Plans (ISPs) were reviewed for compliance, that: 1. An ISP was developed and implemented within ten (10) calendar days of admission for each resident residing in the facility. 2. Addressed those areas of need as identified in the resident evaluation and through staff observation.	A 026	A 026- , Evaluations are done every 6 months. If there is no change in condition, no change is noted. If a change occurs, such as a hospital admission, POAs and their PCPs are contacted immediately. Documentation on resident's evaluations will start including diagnosis and health conditions. If a Hoyer lift is needed/ discussed, documentation will also be included in the evaluations and signed off by the Nurse. Evaluations will be completed within (15) days prior to admission and again every 6 months as usual.	8-30-2023

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A 026	Continued From page 38 3. Detailed the services that are provided by the facility as well as the services to be provided by other agencies. 4. Were 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. These deficient practices could likely result in the residents not receiving appropriate care/services if the: 1. Direct Care Staff (DCS) were not aware of what care and services the resident's needs, 2. ISPs are not current, and include who will provide the care and services and how/where the care and services are to be provided. The finding are: R #1 A. Record review of R #1's (admission date: [redacted]/22) ISP dated [redacted], revealed: 1. R #1 uses [redacted] wheelchair to get around on [redacted] own for mobility. 2. There is no documentation that the ISP was updated to reflect R #1's change in health status as documented on [redacted] evaluation dated [redacted]/23, documenting that R #1 does not wheel [redacted] around on [redacted] own, and is a full assist with all Activities of Daily Living (ADL's). B. Record review of R #1's [redacted]/Home Health Verbal Care Conference form, revealed that R #1 was admitted to [redacted] services on [redacted] and that a Hoyer Lift would be provided along with other equipment and supplies. There was no documentation as to why R #1 would need a Hoyer lift. C. On [redacted]/23 at 11:30 am, during an interview with the House Manger, she confirmed that there	A 026	A 026-A thru D, ISPs will be updated with the resident's diagnosis and current health conditions and signed off by the Nurse. Hospice nurse will need to give orders on why the resident would need a Hoyer lift. When an order has been placed the ISP will be update with current orders.	8-30-2023

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A 026	Continued From page 39 was no documentation showing that her (R#1) ISP reflected the need for full assistance on mobility. D. On [redacted]/23 at 11:11 am, during an interview, the House Manager confirmed that R #1 was admitted to [redacted] on [redacted] and received an order for the use of a Hoyer lift and it was not reflected on her ISP. R #2 E. Record request for R #2's (admission date: [redacted]23) ISP, revealed no documentation that an ISP had ever been created and/or implemented within 10 days after admission to the facility. F. On [redacted]23 at 2:30 pm, during an interview with the House Manager, she confirmed that there was no documentation that an ISP for R #2 was ever created within ten (10) calendar days of [redacted] admission or at anytime since, prior to this survey. R #4 G. Record review of R #4's most recent ISP dated [redacted]/23, revealed no documentation that of the following: 1. The the resident required the use of a Hoyer lift for transfers. 2. That R #4 was receiving [redacted] services since [redacted] 3. Coordination of care with the [redacted] agency showing what services the agency was providing and what services were being provided by the facility DCS. 4. R #4's ISP was updated when R #4 graduated from [redacted] service on [redacted]	A 026	A 026-E, F, House manager will make sure to have ISPs completed by the 10th day of admission. House manager will create a list and sign off on it to ensure that the 10 days of admission is implemented.	8-30-2023

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A 026	Continued From page 40 H. On [redacted]/23 at 8:22 am, during an interview with the House Manager, she confirmed R #4's ISP was not reviewed or updated when the resident: 1. Went on [redacted] or when [redacted] graduated from [redacted] 2. Did not include coordination of care between the [redacted] provider and the facility. Received an order for a Hoyer lift when [redacted] went on [redacted] 3. A new order (dated: [redacted]) for the Hoyer lift to use as needed. R #6 I. Record review of R #6's (admission date: [redacted]/19) resident file revealed: 1. [redacted] and Home Health verbal Care Conference [redacted] stated [redacted] will: a. Provide supplies as needed. b. Assist with showers during covid. c. Provide medications as needed. 2. [redacted] and Home Health verbal Care Conference (dated [redacted]) stated: a. [redacted] will provide bathing twice weekly. b. Hoyer if needed. 3. A physician order (dated [redacted] that provided: a. An order for the use of a Hoyer lift. b. Admission to [redacted]. J. Record review of R #6's most recent ISP dated [redacted]/23 revealed, there is no documentation showing that the ISPs were reviewed and updated when there is a significant change in the resident's health status, such as documenting the level of care addressed on the: 1. [redacted] and Home Health verbal Care Conference dated [redacted] 2. [redacted] and Home Health verbal Care	A 026	A 026-G-H, ISPs will be updated with current health conditions/diagnosis. Hoyer lifts will be included/updated if resident is requiring the use of a Hoyer lift and when the Hoyer lift is no longer needed. Coordination of care between the Hospice provider and facility will be implemented when determining the use of the Hoyer lift and management will document and maintain updates in residents file. A 026-I-K, Updates on all ISPs will be documented by House manager. Significant changes in health status. will be addressed and documented as needed.	8-30-2023

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A 026	Continued From page 41 Conference dated [redacted] K. On [redacted]/23 at 2:00 pm, during an interview with the House Manger, she confirmed the above findings for R #6's ISPs.	A 026		
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,	A 032		

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A 032	Continued From page 42 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. & 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 . 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	A 032		

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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 resident file and Incident Reports were reviewed for compliance that:
1. The facility reported any incident or unusual occurrence (including unexpected death) 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. Conducted an internal investigation, and submitted an investigation follow-up report to the Licensing Authority within 5 business days from the date an incident occurred.

These deficient practices could likely result in the residents to be at risk of harm, injury, and/or death, if incidents occur and there is no oversight by the Licensing Authority.

The findings are:

A. Record review of Complaint Intake [redacted] received on [redacted]23, revealed that the Complainant (a local Police Officer (PO) #1) received a call for service on [redacted]/23 at the facility regarding the death of R #2 and according to the report:
1. R #2 was a full-code (full support which includes cardiopulmonary resuscitation (CPR)) and did not have a DNR (Do Not Resuscitate) order in place and no one preformed CPR.
2. The DCS in charge of R #2's care had no medical training (except for an expired CPR card) and asked DCS #4 to confirm death when R #2

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A 032	Continued From page 44 was found not breathing. 3. A Manager was notified and emergency services were not called until 20-40 minutes after R #2 was found not breathing. 4. PO #1 entered R #2's room and observed [redacted] laying in the bed on [redacted] back. 5. PO #1 attempted to locate a pulse but could not detect a pulse at that time. 6. PO #1 examined R #2's eyes and found them fixed and unresponsive, along with stiffening of the small muscles in the residents eyelids and fingers prior to the PO's arrival and CPR was not initiated. 7. PO #1 then informed PO #2 that R #2 was deceased and canceled incoming rescue units and requested an OMI (Office of Medical Investigator) be sent to the facility. 8. PO #1 took photographs of the deceased (R #2) and the room. PO #2 began interviewing the DCS. Over the course of police officers investigation they determined the following: a. At approximately 3:30 am to 4:00 am, DCS #3 heard coughing from the resident's room and checked on R #2. According to DCS #3, R #2 had a phlegm-like (Mucus) around [redacted] mouth, was provided water, and was not checked on again. b. At approximately 6:30 am to 6:40 am, while doing medication rounds, DCS #3 observed R #2 not breathing. c. DCS #3 called DCS #4 to the R #2's room to confirm [redacted] was not breathing. d. DCS #2 who usually worked in sister facility next door informed the PO's that she was only in this facility to get coffee and overheard DCS #s 3 and 4 saying [redacted] (R #2) not breathing". e. DCS #2 went to R #2's room to check on [redacted] and then called the House Manager. f. The House Manager arrived sometime later and did not call the non-emergency line until approximately 7:07 am.	A 032		

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g. At no time were life-saving measures taken despite R #2 being a full-code without a Do Not Resuscitate order (DNR) in place.
9. OMI (Office of the Medical Investigator) Field Deputy arrived at approximately 8:17 am.
10. OMI pathologist (a medical doctor with specialized training to study medical conditions using human tissue, blood, urine and other body fluids) was concerned with the timeline given by the facility's employees and ordered R #2's body be taken for a full autopsy.

B. On [redacted]23 at 2:45 pm, during an interview with the complainant, he confirmed:
1. He had not yet received a report back from the OMI.
2. When he arrived at the facility, his observation of R #2, was that [redacted] had already been dead for a few hours.
3. He was told by DCS #3 that:
a. R #2 had been in distress earlier in the night.
b. At about 3:00 am, R #2 had been coughing and had some kind of mucus around her mouth, DCS #3 gave her a rag and a glass of water.
c. They just le[redacted] there until the medication pass and then when they did their medication pass, DCS #3 had said that she left R #2 for last rather than checking on[redacted] first, because she knew that R #2 had been having some kind of distress a few hours earlier.
d. Staff at the facility observed that R #2 was deceased and did not start CPR (Cardiopulmonary resuscitation is an emergency procedure consisting of chest compressions often combined with artificial ventilation in an effort to manually preserve intact brain function until further measures are taken to restore spontaneous blood circulation and breathing in a person who is in cardiac arrest).
e. DCS #3 wasn't CPR certified (trained to

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perform CPR on individuals experiencing cardiac arrest).
4. DCS #3 stated that the DCS on site at the time decided that their best option instead of calling emergency services first, was to call the on call Manager (who was the House Manager at that time) first.
5. He (complainant) arrived at 7:00 am, and when he got there, [redacted] (R #2) had rigor (stiffness) and there was no signs of life and [redacted] was already starting to get stiff.
6. He (complainant) has worked EMS (Emergency Medical Services) and law enforcement for several years and believed that R #2 had probably already been dead for a couple hours at least.
7. R #2 was a full code (defined as full support which includes CPR, if the patient has no heartbeat and is not breathing), staff at the facility (unknown who) told him that they were attempting to get a DNR but one was not in place at the time of [redacted] death.

C. Record review of the Pathologist's external examination on [redacted] 23 revealed, R #2 was pronounced dead on [redacted] at [redacted] and the cause of death was [redacted]

D. On [redacted] 23 at 11:30 am, during an interview with the House Manager, she confirmed:
1. R #2 was admitted into the facility on [redacted]
2. They do not provide DCS with first aid training except for just basic wound care training.
3. DCS are required to check on the residents every hour on every shift.
4. DCS#3 said she had just cleaned R #2's mouth because [redacted] had like white foam in [redacted] mouth and then DCS #3 later found R #2 on [redacted]

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A 032	Continued From page 47 last rounds of checking the residents, and [redacted] had passed early in the morning. 5. The ambulance was called because DCS #3 called her (House Manager) and said she (DCS #3) wasn't sure if R #2 was breathing, so she (House Manager) advised DCS #3 to go check for a pulse and see if R #2's stomach was moving. 6. She (House Manager) was not sure if R #2 had a DNR or not. 7. In the event that residents do not have a DNR, the staff are to call 911 right away for resuscitation (process of reviving someone from unconsciousness or apparent death), because the facility does not require their staff to do CPR. F. On [redacted] 23 at 11:50 am, during an interview with DCS #2 (hire date: [redacted]/17), she confirmed: 1. She has not received any training on reporting of incidents since she was first hired. 2. DCS #3 was at the facility with DCS #4 and she was scheduled to work at the other house, but was there to get coffee and was caught in the middle of the incident. 3. DCS #3 and DCS #4 told her that R #2 wasn't breathing, and she told them that they needed to call 911. 4. She does not know who called 911 and when because she had to return to the other house for her shift. G. On [redacted]/23 at 1:52 pm, during an interview with the House Manager, she confirmed that the incident and death involving R #2: 1. Was not reported to the to the Licensing Authority complaint hotline within twenty-four (24) hours or by the next business day, 2. The facility did not submit an investigation follow-up report to the Licensing Authority within 5 business days from the date an incident occurred.	A 032	A032 F: All DCS are trained on incident reporting per DOH regulations on a yearly basis. House Manager trains and monitors. A 032- G (1, 2), House manager will report to the Licensing Authority complaint hotline within 24 hours of an incident of a death. House manager will also submit an investigation follow-up report to the Licensing Authority within 5 days for the date on an incident occurred.	08/30/2023

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A 033	7 NMAC 8.2.33 Resident Rights RESIDENT RIGHTS: All licensed facilities shall understand, protect and respect the rights of all residents. A. Prior to admission to a facility, a resident and legal representative shall be given a written description of the legal rights of the resident, translated into another language, if necessary, to meet the resident ' s understanding. B. If the resident has no legal representative and is incapable of understanding his or her legal rights, a written copy of the resident's legal rights shall be provided to the most significant responsible party in the following order: (1) the resident's spouse; (2) significant other; (3) any of the resident's adult children; (4) the resident's parents; (5) any relative the resident has lived with for six or more months before admission; (6) a person who has been caring for, or paying benefits on behalf of the resident; (7) a placing agency; (8) resident advocate; or (9) the ombudsman. C. The resident rights shall be posted in a conspicuous public place in the facility and shall include the telephone numbers for the incident management hotline and for the state ombudsman program. D. To protect resident rights, the facility shall: (1) treat all residents with courtesy, respect, dignity and compassion; (2) not discriminate in admission or services based on gender, sexual orientation, resident's age, race, religion, physical or mental disability, or nationality; (3) provide residents written information about all services provided by the facility and their costs	A 033		

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and give advance written notice of any changes;
(4) provide residents with a safe and sanitary living environment;
(5) provide humane care for all residents;
(6) provide the right to privacy, including privacy during medical examinations, consultations and treatment;
(7) protect the confidentiality of the resident ' s medical record;
(8) protect the right to personal privacy, including privacy in personal hygiene; privacy during visits with a spouse, family member or other visitor; and privacy in the resident's own room;
(9) protect the right to communicate privately and freely with any person, including private telephone conversations and private correspondence; and the right to receive visits from family, friends, lawyers, ombudsmen and community organizations;
(10) prohibit the use of any and all physical and chemical restraints;
(11) ensure that residents:
(a) are free from physical and emotional abuse neglect and misappropriation/or exploitation;
(b) are free from financial abuse and misappropriation by facility staff or management;
(c) are free to participate in religious, social, community and other activities and freely associate with persons in and out of the facility;
(d) are free to leave the facility and return without unreasonable restriction;
(e) are given a fifteen (15) calendar day, written notice before room transfers or discharge from the facility unless there is immediate danger to self or others in the facility;
(f) have an environment that fosters social interaction and avoids social isolation;
(g) or their surrogate decision makers, are informed of and consent to the services provided

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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 033	Continued From page 50 by the facility; (h) have the right to voice grievances to the facility staff, public officials, the ombudsmen, any state agency, or any other person, without fear of reprisal or retaliation; (i) have the right to have their complaints addressed within fourteen (14) calendar days or sooner; (j) have the right to participate in the development of their care plan/ISP; (k) have the right to choose a doctor, pharmacist and other health care provider(s); (l) have the right to participate in medical treatment decisions and formulate advance directives such as living wills and powers of attorney; (m) have the right to keep and use personal possessions without loss or damage; (n) have the right to manage and control their personal finances; (o) have the right to freely organize and participate in a resident association that may recommend changes in the facility's policies, services and management; (p) shall not be required to work for the facility; and (q) are protected from unjustified room transfers or discharge. E. The resident's rights shall not be restricted unless this restriction is for the health and safety of the resident, agreed to by the resident or the resident ' s surrogate decision maker and outlined in the resident ' s individual service plan. [7.8.2.33 NMAC - Rp, 7.8.2.34 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by:	A 033		

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	4048	A. BUILDING: _____ B. WING _____	C 07/06/2023

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A 033	Continued From page 51 7.8.2.33 D 11 (a) Based on record review and interview, the facility failed to ensure for [redacted] resident who was a "Full-Code" (a medical term that means a patient wants resuscitation and all life-saving measures during a medical emergency) that: 1. 911 was called and Emergency Medical Services (EMS) were requested when [redacted] discovered to not be breathing. 2. The Direct Care Staff (DCS) had knowledge of the resident's choice to be resuscitated (revive) if found to not be breathing. This deficient practice likely resulted in a delay in initiation of life saving efforts, resulting in resident's death. The findings are: A. Record review of Complaint Intake [redacted] (dated [redacted]/23) revealed the following: 1. The local Police Department received a call for service on [redacted]/23 at the facility regarding the death of R #2, and the police: a. Entered R #2's room and observed [redacted] laying in the bed on [redacted] back. b. Attempted to locate a pulse but could not detect a pulse at that time. c. Examined R #2's eyes and found them fixed and unresponsive, along with stiffening of the small muscles in the eyelids and fingers. d. Confirmed CPR (Cardiopulmonary Resuscitation) was not initiated on R #2. 2. The responding police officer interviewed DCS #3 and confirmed: a. At approximately 3:30 am to 4:00 am, DCS #3 heard coughing from the resident's room and checked on R #2. b. DCS #3 stated that R #2 had a phlegm-like (mucus) around [redacted] mouth and was provided	A 033		

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A 033	Continued From page 52	A 033		

water and was not checked on again until approximately 6:30 am to 6:40 am, while doing medication rounds, when DCS #3 observed R #2 not breathing.
c. DCS #3 called DCS #4 to the R #2's room to confirm [redacted] not breathing.
3. The responding police officer interviewed DCS #2 and confirmed:
a. She overheard DCS #3 and DCS #4 saying, [redacted] not breathing."
b. DCS #2 went to R #2's room to check and then called the House Manager.
4. The House Manager called the non-emergency line at approximately 7:07 am.
5. At no time were life-saving measures taken despite R #2 being a full-code (defined as full support which includes CPR, if the patient has no heartbeat and is not breathing) without a do not resuscitate order (DNR) in place.
6. OMI (Office of Medical Investigator) Field Deputy arrived at approximately 8:17 am.
7. OMI pathologist (a medical doctor with specialized training to study medical conditions using human tissue, blood, urine and other body fluids) was concerned with the timeline given by the facility's employees and ordered R #2's body taken for a full autopsy.

B. On [redacted]/23 at 2:45 pm, during an interview with the complainant (responding officer) he confirmed:
1. He has not heard back from OMI regarding the autopsy report and is not aware of the cause of death for R #2.
2. When he arrived at the facility on the date of the incident at 7:00 am, based on his observation and with his professional experience as an EMS and law enforcement for several years, it appeared that R #2 had been dead for a few hours based on the stage of rigor mortis

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A 033	Continued From page 53	A 033		

(stiffening of the joints and muscles of a body a few hours after death) and there was no signs of life.

3. He learned from staff that R #2 was a full code and staff at the facility (unknown who) told him that they were attempting to get a DNR but one was not in place at the time and staff at the facility saw that R #2 was deceased and didn't try CPR.

4. He completed an interview with DCS #3 after arriving at the facility on the date of the incident and she confirmed with him:

a. R #2 had been in distress earlier in the night at about 3:00 am, and had been coughing and had some kind of mucus around [redacted] mouth, so she (DCS #3) gave R #2 a rag and a glass of water.

b. She (DCS #3) left R #2 in bed/in [redacted] until the morning medication pass.

c. She (DCS #3) was not CPR certified (a credential that qualifies the holder to perform a life-saving procedure on someone who cannot breathe on their own due to a near-drowning incident, suffocation or a cardiac event) anymore and her CPR had lapsed sometime before.

d. Herself (DCS#3) and the other DCS on site, decided that their best option was to call the on call the House Manager at that time, first, instead of calling emergency services first.

C. Record review of R #2's (admission date: [redacted] 23) resident file revealed, there was a Physician's order for life sustaining treatment (any treatment that serves to prolong life without reversing the underlying medical condition) on file (not dated), and there was no documentation of a DNR being in place at the time of the incident.

D. Record review of the pathologist external examination on [redacted] revealed, R #2 was pronounced dead on [redacted].

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A 033	Continued From page 54 E. On [redacted]/23 at 5:00 pm, during an interview with R #2's Son-in-Law, he confirmed: 1. His wife received a call from staff (unknown) at the facility and advised that they found R #2 during their early morning check and had gone in to help clear [redacted] mouth of some mucus and [redacted] (R #2) wasn't happy about it so staff told[redacted] that they would turn the TV on and when she (unknown DCS) came back to check on R #2 around 7:00 am, [redacted] was non responsive. 2. Staff (unknown) told him that R #2 had passed away in [redacted] sleep from natural causes. F. On [redacted]/23 at 11:30 am, during an interview with the House Manager, she confirmed: 1. R #2 had just moved into the facility on [redacted]/23 and [redacted] passed early in the morning on [redacted] 2. DCS are required to check on the residents every hour on every shift. 3. DCS #3 said she had just cleaned R #2's mouth because [redacted] like white foam in [redacted] mouth and then DCS #3 later found R #2 not responsive on her last rounds of checking the residents. 4. On the date of the incident, she (House Manager) received a call from DCS #3 advising her that she was not sure if R #2 was breathing, so she told DCS #3 to check the resident for a pulse and to see if [redacted] stomach was "moving" to indicate if [redacted] was breathing. After that, she called for an ambulance. 5. She (House Manager) was not sure if R #2 had a DNR or if [redacted] was a full code. 6. For residents who do not have a DNR, and are a full code, she (House Manager) stated that facility staff are supposed to call 911 immediately because they don't require their staff to do CPR on residents.	A 033		

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A 033	Continued From page 55 G. On [redacted]/23 at 1:29 pm, during an interview with the Administrator, he confirmed: 1. R #2 was found not breathing and staff (could not recall who) called 911 and handled the situation the way they would handle a DNR/DNI (do not incubate). 2. R #2 was a full code and they told R #2's family previously that they needed to get [redacted] DNR/DNI paperwork completed but did not do so before the date of the incident. H. On [redacted]/23 at 1:52 pm, during an interview with the House Manager, she confirmed: 1. R #2 was a DNR and remembers highlighting that on R #2's paperwork (unknown document) and would provide documentation since the documentation previously provided indicated that R#2 was a full code. I. On [redacted]/23 at 2:10 pm, during an interview with R #2's Son-in-Law, he confirmed: 1. R #2 did not have a DNR in place and had an advanced directive and was a full code. 2. They had the Physician's order for life sustaining treatment paperwork signed and completed by the physician assistant when they took R #2 in for an exam as a requirement from the facility prior to moving in. 3. The facility asked them when moving in, if R #2 had a DNR in place and they told them that there was an advanced directive in place and provided the facility with a copy. 4. He does not recall being told by the facility that a DNR was required for R #2 and they did not have the intentions nor were they in the process of having one completed prior to the date of the incident. J. On [redacted]23 at 2:00 pm, during an interview	A 033		

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A 033	Continued From page 56 and exit conference with the House Manger, she confirmed that documentation was not received showing there was a DNR in place for R #2.	A 033	A033 House Manager will confirm documentation for advanced directives at admission for each resident. House Manager will review documentation with POA/Guardian.	08/30/2023
A 034	7 NMAC 8.2.34 Custodial Drug Permits CUSTODIAL DRUG PERMITS: A facility with two (2) or more residents that is licensed pursuant to this rule and that assists with self-administration or safeguards medications for residents shall have a current custodial drug permit issued by the state board of pharmacy. A. Procurement, labeling and storage. The facility shall provide assistance to the resident in obtaining the necessary medications, treatment and medical supplies as identified in the ISP. The facility shall procure, label and store medications for residents who require assistance with self-administration of medication in compliance with state and federal laws. (1) All medications, including non-prescription drugs, shall be stored in a locked compartment or in a locked room, as approved by the board of pharmacy and the key shall be in the care of the administrator or designee. (2) Internal medication shall be kept separate from external medications. Drugs to be taken by mouth shall be separated from all other delivery forms. (3) A separate, locked refrigerator shall be provided by the facility for medications. The refrigerator temperature shall be kept in compliance with the state board of pharmacy requirements for medications. (4) All medications, including non-prescription medications, shall be stored in separate compartments for each resident and all medications shall be labeled with the resident's name.	A 034		

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A 034	Continued From page 57 (5) A resident may be permitted to keep his or her own medication in a locked compartment in his or her room for self-administration, if the physician's order deems it appropriate. (6) The facility shall not require the residents to purchase medications from any particular pharmacy. (7) Medical gases (oxygen) and equipment used for the administration of inhalation therapy and for resuscitative purposes shall comply with the national fire protection association (NFPA) 99. (8) A proof of use record shall be maintained separately for each schedule II through IV drug (controlled substances). The proof of use sheet shall document: (a) the type and strength of the schedule II through IV drugs; (b) the date and time staff assisted with self-administration; (c) the resident ' s name; (d) the prescriber ' s name; (e) the dose; (f) the signature of the person assisting with delivery of the medication; and (g) the balance of medication remaining. (9) Any remaining medication discontinued by a physician ' s order, or upon discharge or death of the resident shall be inventoried and moved to a separate locked storage container. Such discontinued medications shall be destroyed upon the next quarterly visit by the consulting pharmacist in accordance with 16.19.11.10 NMAC. (10) The record of medication destruction shall be signed by the administrator or designee and the pharmacist and shall be kept on file at the facility. B. Consulting pharmacist. The facility shall maintain records demonstrating that the	A 034		

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A 034	Continued From page 58 consulting pharmacist provides the following oversight and guidance. (1) Reviews the medication regimen as needed, but at least quarterly/every three (3) months, to determine that all medications and records are accurate and current. All irregularities shall be reported to the administrator of the facility and these irregularities shall be resolved by the administrator within seventy-two (72) hours. (2) A system of records of receipt and disposition of all drugs in sufficient detail to enable an accurate reconciliation. (3) Consultation shall be provided on all aspects of pharmacy services in the facility, including reference information regarding side effects and, when needed, physician consultation in cases involving the use of psychotropic medications. (4) The consulting pharmacist will be responsible for assuring that the facility meets all requirements for storage, labeling, destruction and documentation of medications as required by the state board of pharmacy, 16.19.11.10 NMAC and 7.8.2 NMAC. [7.8.2.34 NMAC - Rp, 7.8.2.35 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.34 A (7) Refer to: NFPA (National Fire Prevention Association) 99. 2012 Edition. 11.3 Cylinder and Container Storage Requirements. 11.3.1* Storage for nonflammable gases equal to or greater than 85 m3 (3000 ft3) at STP shall comply with 5.1.3.3.2 and 5.1.3.3.3. 11.3.2* Storage for nonflammable gases greater than 8.5 m3 (300 ft3), but less than 85 m3 (3000	A 034		

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A 034	Continued From page 59 ft3), at STP shall comply with the requirements in 11.3.2.1 through 11.3.2.3. 11.3.2.1 Storage locations shall be outdoors in an enclosure or within an enclosed interior space of noncombustible or limited combustible construction, with doors (or gates outdoors) that can be secured against unauthorized entry. 11.3.2.2 Oxidizing gases, such as oxygen and nitrous oxide, shall not be stored with any flammable gas, liquid, or vapor. 11.3.2.3 Oxidizing gases such as oxygen and nitrous oxide shall be separated from combustibles or materials by one of the following: (1) Minimum distance of 6.1 m (20 ft) (2) Minimum distance of 1.5 m (5 ft) if the entire storage location is protected by an automatic sprinkler system designed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems (3) Enclosed cabinet of noncombustible construction having a minimum fire protection rating of 1/2 hour 11.3.2.4 Gas cylinder and cryogenic liquid container storage shall comply with 5.1.3.5.12. 11.3.2.5 Cylinder and container storage locations shall comply with 5.1.3.3.1.7 with respect to temperature limitations. 11.3.2.6 Cylinder or container restraints shall comply with 11.6.2.3. 11.3.2.7 Smoking, open flames, electric heating elements, and other sources of ignition shall be prohibited within storage locations and within 6.1 m (20 ft) of outside storage locations. 11.3.2.8 Cylinder valve protection caps shall comply with 11.6.2.3. 11.3.2.9 Gas cylinder and liquefied gas container storage shall comply with 5.1.3.5.12. 11.3.3 Storage for nonflammable gases with a total volume equal to or less than 8.5 m3 (300 ft3) shall comply with the requirements in 11.3.3.1	A 034		

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A 034	Continued From page 60 and 11.3.3.2. 11.3.3.1 Individual cylinder storage associated with patient care areas, not to exceed 2100 m2 (22,500 ft2) of floor area, shall not be required to be stored in enclosures. 11.3.3.2 Precautions in handling cylinders specified in 11.3.3.1 shall be in accordance with 11.6.2. 11.3.3.3 When small-size (A, B, D, or E) cylinders are in use, they shall be attached to a cylinder stand or to medical equipment designed to receive and hold compressed gas cylinders. 11.3.3.4 Individual small-size (A, B, D, or E) cylinders available for immediate use in patient care areas shall not be considered to be in storage. 11.3.3.5 Cylinders shall not be chained to portable or movable apparatus such as beds and oxygen tents. 11.3.4 Signs. 11.3.4.1 A precautionary sign, readable from a distance of 1.5 m (5 ft), shall be displayed on each door or gate of the storage room or enclosure. 11.3.4.2 The sign shall include the following wording as a minimum: CAUTION: OXIDIZING GAS(ES) STORED WITHIN (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. Based on observation and interview, the facility failed to ensure that oxygen cylinders were stored securely, protected from accidental damage or dislocation, and separate from combustibles (wooden bookcase, baskets, compact discs and covers, carpet).	A 034		

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A 034	Continued From page 61 This deficient practice could likely result in the [redacted] residents identified on the census provided by the Administrator on [redacted]/23, to be at risk of harm, injury, or death if the oxygen cylinder tanks were to fall over damaging the valve, causing it to depressurize during a fire, the oxygen feeds the fire, causing it to spread faster and/or the cylinder tanks act like missiles and hit a resident/staff/rescuer during a fire. The findings are: A. On [redacted]/23 at 9:50 am, during observation of resident [redacted] 1 small unsecured oxygen cylinder tank and 1 tall secured tank were observed in the room with a carpeted floor, next to a wooden bookshelf with baskets of plastic compact discs (CD's) and covers. B. On [redacted]/23 at 10:16 am, during observation of the facility's designated oxygen storage container (exterior storage unit-East side of building), 6 large and 1 small unsecured tanks were observed. C. On [redacted]/23 at 2:30 pm, during an interview with the House Manager, she confirmed the oxygen tank storage findings listed above.	A 034	A 034-A thru C, Room 14, oxygen tanks were taken to the oxygen storage container and were secured by a chain. The designated oxygen storage container located on the northwest side of the building was secured by a chain and shown to surveyor. POC was immediately corrected. The chain will stay in place to hold the tanks. House manager will monitor to ensure ongoing compliance.	6-23-2023
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 the national academy of sciences. Meals shall meet the nutritional needs of the residents in	A 036		

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A 036	Continued From page 62 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 (h) contact the resident ' s PCP within forty-eight (48) hours if a resident consistently refuses to	A 036		

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A 036	Continued From page 63 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 cleaning. (b) Utensils shall be stored in a clean, dry place	A 036		

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A 036	Continued From page 64	A 036		

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 with the local health authority.
D. Food management. The facility shall store,

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A 036	Continued From page 65 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. (6) Canned or preserved foods shall be procured from sources that process the food under	A 036		

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A 036	Continued From page 66 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, 01/15/2010]	A 036		

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A 036	Continued From page 67 This REQUIREMENT is not met as evidenced by: 7.8.2.36 C (1) (a) D (3 & 4) Based on observation and interview, the facility failed to ensure: 1. Food stored in refrigerators and freezers were covered, dated, and labeled. 2. Clean and sanitary kitchen work space (absent of exposed food and crumbs). 3. The temperature for all hot foods was maintained at one hundred forty (140) degrees Fahrenheit (F). These deficient practices could likely cause the [redacted] residents listed on the census provided by the Administrator on [redacted]/23, to be at risk for harm or contracting foodborne illnesses if: 1. Food, was not stored properly (dated and labeled), including food items left uncovered and undated on kitchen counter. 2. Kitchen work space is not clean and sanitary (free of exposed food and crumbs). 3. The hot food is not maintained at 140 degrees, and the residents consume foods that are not served at safe temperatures. The findings are: A. On [redacted]/23 at 10:57 am, during an observation of the facility's kitchen refrigerator, the following items were observed: 1. One (1) half cut apple in sealed plastic bag, was not labeled or dated. 2. One (1) three (3) lb. used plastic container of green grapes, was not labeled or dated. 3. One (1) three (3) lb. used plastic container of	A 036		

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A 036	Continued From page 68 strawberries, was not labeled or dated. B. On [redacted]/23 at 11:12 am, during an observation of the facility's kitchen freezer, one (1) 48 ounce (oz.) sealed plastic bag of walnuts, was not dated or labeled. C. On [redacted]/23 at 11:15 am, during an observation of the facility's kitchen work space (kitchen counter), the following items were observed: 1. One (1) orange slice laying on top of a cutting board covered with food crumbs, was not covered or sealed in a bag or container, and was not labeled or dated. 2. One (1) English muffin laying on top of a cutting board covered with food crumbs, was not covered or sealed in a bag or container, and was not labeled or dated. 3. Two (2) slices of bacon lying on top of a napkin on the kitchen counter, was not covered or sealed sealed in a bag or container, and was not labeled or dated. D. On [redacted]23 at 12:12 pm, during observation of the facility's lunch meal delivered to the small office, the temperature for a cooked hamburger patty was observed to be 103 degrees F. E. On [redacted]23 at 2:30 pm, during an interview with the Administrator, she confirmed: 1. The above items observed in the kitchen refrigerator and freezer were not properly covered, dated and/or labeled. 2. The above items observed laying on the kitchen work space/counter (atop a cutting board with crumbs) were not sealed in a bag or container, and were no labeled or dated. 3. The food temperature for the hamburger patty served during the lunch meal was observed to be	A 036	A 036- A thru C (1-3), Refrigerator items will be covered, labeled and dated. Kitchen cook will check the refrigerated/freezer on a weekly basis and make sure we are in compliance. Kitchen counters will be sanitized and clean by the kitchen cook after each meal. House manager will have weekly meetings with the kitchen cook to address any needs/issues that might arise. A 036- E, House cook monitors food temperatures by using a food thermometer to ensure hot foods are maintained at 140 degrees Fahrenheit. House manager monitors kitchen log to ensure compliance.	6-23-2023

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A 036	Continued From page 69 below the required 140 degrees F.	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] 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		

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A 038	Continued From page 70 This deficient practice could likely result in the [redacted] residents listed on the census list provided by the Administrator on [redacted]/23, 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 [redacted]/23 at 9:13 am, during observation of the resident restroom/bath revealed, one (1) 14 oz can of disinfectant and sanitizer spray was observed in the unlocked cabinet above the sink. B. On [redacted]23 at 9:26 am, during observation of the facility's unlocked storage closet the following items were observed: 1. Two (2) one quart bottles of odor eliminator. 2. One (1) box of 12 count 14 oz bottles of disinfectant and sanitizer. 3. One (1) 14 oz bottle of disinfectant and sanitizer. 4. Three (3) one gallon bottles of alcohol antiseptic solution, hand and surface cleaner. C. On [redacted]/23 at 2:30 pm, during an interview with the House Manager, she confirmed that the chemicals located in the resident restroom/bath and the facility's unlocked storage closet were unsecured and accessible to residents.	A 038	A 038- A thru C, Disinfectants and sanitizer sprays are locked up in the storage room that requires a combination code. Management will make her rounds to ensure all doors with combinations are securely closed. Staff will be reminded to make sure the doors are closed correctly at all times.	8-30-2023
A 042	7 NMAC 8.2.42 Maintenance of Building and Grounds MAINTENANCE OF BUILDING AND GROUNDS: The building(s) shall be maintained in good repair at all times. Such maintenance shall include, but is not limited to, the following areas: A. Storage areas/grounds. Storage areas and	A 042		

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A 042	Continued From page 71 grounds shall be maintained in a safe, sanitary and presentable condition at all times. Storage areas and grounds shall be kept free from accumulation of refuse, weeds, discarded furniture, old newspapers or other items that create a fire hazard. B. Floors. Floors shall be maintained stable, firm and free of tripping hazards. [7.8.2.42 NMAC - Rp, 7.8.2.43 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.42 Based on observation and interview, the facility failed to ensure the building was maintained and in good repair at all times. This deficient practice could likely cause the [redacted] residents listed on the census provided by the Administrator on [redacted]/23, to be at risk of harm if the facility is not in good repair and free of environmental hazards. The findings are: A. On [redacted]/23 at 9:57 am, during observation of [redacted] one (1) electrical bathroom light switch cover was observed to be loose and exposing a small opening from the wall. B. On [redacted]/23 at 1:29 pm, during an interview with the House Manager, she confirmed resident bathroom light switch cover was loose and there was a small opening in the wall.	A 042	A 042- A, B, Light switch cover for Room 10 was replaced. Weekly checks will be documented when rooms 1-15 are checked for any maintenance and repairs that are needed.	6-30-2023

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A 045	Continued From page 72	A 045		
A 045	7 NMAC 8.2.45 Water WATER: Pursuant to the current New Mexico drinking water requirements, 7.6.2.9 NMAC. A. The water supply system shall be constructed, protected, operated and maintained in conformance with applicable local, state and federal laws, ordinances and regulations. B. Where a facility is supplied by its own water system, the system shall meet the sampling and construction requirement of a non-community water system as defined by the current New Mexico drinking water requirements. C. All water that is not piped into the facility directly from a public water supply system shall be from an approved source, disinfected, transported, handled, stored and dispensed in a sanitary manner. Such water shall be prevented from entering potable water systems by appropriate cross connection and backflow prevention devices. D. Hot and cold running water, under pressure shall be provided in all areas where food is prepared and where equipment and utensils are washed, sinks, lavatories, washrooms and laundries. E. The hot water temperature that is accessible to residents shall be maintained at a minimum of ninety-five (95) degrees fahrenheit and a maximum of one hundred ten (110) degrees fahrenheit. Hot water in excess of one hundred ten (110) degrees fahrenheit is permitted in kitchen and laundry areas, provided that residents are supervised in order to prevent injury. [7.8.2.45 NMAC - Rp, 7.8.2.46 NMAC, 01/15/2010]	A 045		

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A 045	Continued From page 73 This REQUIREMENT is not met as evidenced by: 7.8.2.45 (E) Based on observation and interview, the facility failed to ensure the hot water temperatures were maintained at a maximum of 110 degrees Fahrenheit (F). This deficient practice could likely result in the [redacted] residents listed on the census list provided by House Manager on [redacted] 3/23, to be at risk of harm from being burned by water that is too hot. The findings are: A. On [redacted] 23 from 9:21 am to 9:57 am, during an observation of the facility water temperatures, the following was observed: 1. The community bathroom located in the West hallway of the facility, the sink and bath water temperatures were both 122 degrees F. 2. In [redacted] the bathroom sink water temperature was 121.0 degrees F. 3. In [redacted] the bathroom sink water temperature was 130.0 degrees F. 4. In [redacted] the bathroom sink water temperature was 130.0 degrees F. 5. The community bathroom located in the North hallway, the bath water temperature was 121 degrees F. B. On [redacted] /23 at 2:30 pm, during an interview, the House Manager confirmed the facility's water temperatures were not being maintained at a maximum of 110 degrees Fahrenheit (F).	A 045	A 045-A, B, All temperatures are measured using a digital thermometer. The temperatures were taken, the same way as previously trained by the fire imspector. House manager let the water run for 1.5-2 minutes, than using a cup, while water is still running, dip thermometer until reading stops. This may take another minute. A045-A1 Community Bathroom the temp was 104.2. A2-Bathroom sink in Rm #6 Temp reading was 107.9. A3-Rm 9 bathroom sink temp was 106.9.A4-Rm 10-Temp was 108.6. A5-Community bathroom #2 temp was 105.2. Assistant Manager monitors water temps, House manager reviews and ensures compliance.	6-29-2023
A 047	7 NMAC 8.2.47 Lighting and Lighting Fixtures LIGHTING AND LIGHTING FIXTURES:	A 047		

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A 047	Continued From page 74 A. All areas of the facility, including storerooms, stairways, hallways, and interior and exterior entrances shall be lighted to make the area clearly visible. B. Exits, exit-access ways and other areas used at night by residents and staff shall be illuminated by night lights or other continuous lighting. C. Lighting fixtures shall be selected and located to accommodate the needs and activities of the residents, with the comfort and convenience of the residents in mind. D. Lamps and lighting fixtures shall be shaded to prevent glare to the eyes of residents and staff, and protected from accidental breakage or shattering. E. Facilities with four (4) or more residents shall have emergency lighting to light exit passageways and the exterior area near the exits that activates automatically upon disruption of electrical service. F. Facilities with three (3) or fewer residents shall have a flashlight that is immediately available for use in lieu of electrically interconnected emergency lighting. [7.8.2.47 NMAC - Rp, 7.8.2.48 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.47 C E Based on observation and interview the facility failed to ensure that: 1. All emergency lights in the facility were in working order. 2. Resident bathroom lights were in working order. These deficient practices could likely result in the	A 047		

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A 047	Continued From page 75 [redacted] residents identified on the census provided by the House Manager on [redacted]/23, to be at risk of harm, injury, or death, if: 1. There is a power outage or other emergency requiring evacuation and the residents cannot see to safely exit the building. 2. Resident's bathroom lighting fails to provide sufficient lighting. The findings are: Findings related to emergency lights A. On [redacted]/23 at 9:41 am, during observation and testing of the facilities emergency lights, the emergency light in the South hallway failed to light up when tested. B. On [redacted]/23 at 9:48 am, during observation and testing of the facilities emergency lights, the emergency light in the main dining room failed to light up when tested. Findings related to residential bathroom lights: C. On [redacted]23 at 9:42 am, during observation of [redacted] the bathroom light (three (3) sockets over sink) was observed to need a replacement of one (1) light bulb in order to ensure sufficient lighting. D. On [redacted]/23 at 9:57 am, during observation of [redacted] the bathroom light (three (3) sockets over sink) was observed to need a replacement of one (1) light bulb in order to ensure sufficient lighting. E. On [redacted]23 at 10:12 am, during observation of [redacted] the bathroom light (three (3) sockets over sink) was observed to	A 047	A 047-A, B, Fire monitor company fixed the two emergency lights that were not working. The one on the South hallway and the emergency light in the dining room. Assistant Manager monitor monthly testing. House Manager reviews and ensures compliance. A 047- C thru F, Light bulbs in bathroom rooms 8, 9 and 10 have been replaced. Manager will check Residents bathroom lights on a weekly basis and documentation will be kept in managers office.	6-29-2023

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A 047	Continued From page 76 need a replacement of one (1) light bulb in order to ensure sufficient lighting. F. On [redacted]/23 at 1:29 pm, during an interview with the House Manager, she confirmed all the emergency lights and resident bathroom light findings listed above.	A 047		
A 059	7 NMAC 8.2.59 Windows WINDOWS: A. Each sleeping room shall be provided with an exterior window. (1) The window shall be operable, screened and have a clear operable area of 5.7 square feet minimum; measured twenty (20) inches wide minimum and measured twenty-four (24) inches high minimum. (2) The top of the window sill shall not be more than forty-four (44) inches above the finished floor. B. Screens shall be provided on all operable windows. C. The proposed use of bars, grilles, grates or similar devices shall be reviewed and approved by the licensing authority prior to installation. D. Sleeping rooms, living rooms, activity room areas and dining room areas shall have a window area of at least one tenth (1/10) of the floor area with a minimum of ten (10) square feet. [7.8.2.59 NMAC - Rp, 7.8.2.52 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.59 B Based on observation and interview, the facility	A 059		

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A 059	Continued From page 77 failed to ensure that all operable windows had screens. This deficient practice could likely result in the [redacted] residents identified on the resident census provided by House Manager on [redacted]/23, to be at risk of injury or illness due to bug bites or allergens because the screens on windows were missing. The findings are: A. On [redacted]/23 at 9:52 am, during an observation of the facility, the following windows were found to be missing screens: 1. [redacted] was missing window screen 2. [redacted] was missing a window screen 3. [redacted] was missing a window screen B. On [redacted]23 at 2:30 pm, during an interview with the House Manager, she confirmed the above windows were missing screens.	A 059	A 059- A, Resident's windows were cleaned, and the screens were washed and put back on the windows in rooms 1,2 and 5. House manager will check all the window screens on a monthly basis to make sure that they are in place and have no damage. Monthly checks will be documented and will be available in the manager's office.	6-23-2023
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		

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A 065	Continued From page 78 C. If applicable, the local fire department may be requested to supervise and participate in fire drills. [7.8.2.65 NMAC - Rp, 7.8.2.65 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.65 B (2) (5) Based on record review and interview, the facility failed to ensure that the monthly fire drills records included the following information: 1. The time of the drill 2. The evacuation time in total minutes These deficient practices could likely result in the [redacted] residents identified on the census, provided by the Administrator on [redacted] 23, to be at risk of harm, injury, or death if a fire were to occur and the Direct Care Staff (DCS): 1. On all shifts do not know how to safely evacuate the residents. 2. Do not know how long it takes to safely evacuate the residents from the building. The findings are: A. Record review of the facility's monthly fire drill records for January 2023 through June 2023 revealed: 1. Monthly Fire Drill Log (dated [redacted]/23) did not include the time the drill occurred. 2. Monthly Fire Drill Log (dated [redacted]/23) did not include the time the drill occurred. 3. Monthly Fire Drill Log (dated [redacted]/23) did not include: a. The time the drill occurred.	A 065	A 065-A, B, Fire drills will include the time and when the drill occurred. In the future the evacuation time in total minutes will be documented and checked on a monthly basis by management.	6-29-2023

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A 065	Continued From page 79 b. The evacuation time in total minutes. 4. Monthly Fire Drill Log (dated [redacted]/23) did not include the evacuation time in total minutes 5. Monthly Fire Drill Log (dated [redacted]/23) did not include: a. The time the drill occurred. b. The evacuation time in total minutes. B. On [redacted]/23 at 2:30 pm, during an interview with the House Manager, she confirmed the above findings for the facility fire drill records for January 2023 through June 2023.	A 065		
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	A 068		

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A 068	Continued From page 80	A 068		

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 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

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A 068	Continued From page 81 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; (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.	A 068		

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A 068	Continued From page 82 (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 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	A 068		

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A 068	Continued From page 83	A 068		

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.
(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

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A 068	Continued From page 84 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 Direct Care Staff (DCS) had completed a minimum of six (6) hours per year of palliative/hospice care training. This deficient practice could likely result in the [redacted] residents identified as on the resident census list as receiving [redacted] services, provided by the Administrator on [redacted]/23, to be at risk of harm or injury if DCS have not received training on the proper methods of providing hospice care and services. The findings are: DCS #1 A. Record review of DCS #1's (date of hire: [redacted]/18) annual training records, revealed there was no documentation showing that she had completed a minimum of six (6) hours per year of palliative/hospice care training in 2019, 2020, 2021 and 2022. B. On [redacted]/23 at 4:00 pm, during an interview with DCS #1, she could not remember that the above trainings were provided to her for the years of 2019, 2020, 2021 and 2022. DCS #2	A 068	A 068-A thru G, House Manager has all of the DCS complete 6 hours of palliative/hospice care training yearly. Please see attachment to show how documentation will be kept on all future trainings. DCS 1, 2 and 4 have received annual hospice/palliative care trainings for the years employed in our facility.	6-29-2023

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A 068	Continued From page 85 C. Record review of DCS #2's (date of hire: [redacted]/17) annual training records, revealed there was no documentation showing that she had completed a minimum of six (6) hours per year of palliative/hospice care training in 2018, 2019, 2020, 2021 and 2022. D. On [redacted]/23 at 11:50 am, during an interview with DCS #2, she could not remember that the above trainings were provided to her for the years of 2018, 2019, 2020, 2021 and 2022. DCS #4 E. Record review of DCS #4's (date of hire: [redacted]/20) annual training records, revealed there was no documentation showing that she had completed a minimum of six (6) hours per year of palliative/hospice care training in 2021 and in 2022. F. On [redacted]/23 at 3:30 pm, during an interview with DCS #4, she confirmed: 1. There is no training that is provided for new staff. 2. She does not receive ongoing training. G. On [redacted]/23 at 2:30 pm, during an interview with the House Manager, she confirmed, there was no documentation to show that DCS #'s 1, 2 and 4 received the 6 hours of annual hospice/palliative care trainings for the years listed above.	A 068		