Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	7098	A. BUILDING: _____ B. WING _____	C 03/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANDIA VIEW FOUNTAIN HILL	4551 VISTA FUENTE RD NW ALBUQUERQUE, NM 87114

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 000	Initial Comments The following deficiencies were cited during a Complaint survey completed on 03/05/24 for the state requirements of NMAC 7.8.2, Regulations for Assisted Living Facilities for Adults. Census: 36, Memory Care (MC) 12, Assisted Living (AL) 24 Complaint Intake ID NM #[redacted] was investigated with deficiencies cited.	A 000		
A 020	7 NMAC 8.2.20 Admissions and Discharge ADMISSIONS AND DISCHARGE: The facility shall complete an admission agreement for each resident. The administrator of the facility or a designee responsible for admission decisions shall meet with the resident or the resident ' s surrogate decision maker prior to admission. No resident shall be admitted who is below the age of eighteen (18) or for whom the facility is unable to provide appropriate care. A. Admission agreement. The admission agreement shall include the following information: (1) the parties to the agreement; (2) the program narrative; (3) the facility's rules; (4) the cost of services and the method of payment; (5) the refund provision in case of death, transfer, voluntary or involuntary discharge; (6) information to formulate advance directives; (7) a written description of the legal rights of the residents translated into another language, if necessary; (8) the facility's staffing ratio; (9) written authorization for staff to assist with medications; (10) notification of rights and responsibilities	A 020	1. Resident [redacted] had a Care Conference with [redacted] team to address ISP and resident needs. No further residents were identified to be affected. Additional training on NMAC 8.2.20 was completed on 7/16/2024 with Administrator and Care Coordinators. Training included a review of NMAC 8.2.20 specific to exceptions to admission and proper documentation for admission exceptions regarding Pending and current in-house resident. 2. New admissions will be reviewed based on the following criteria: The facility will either not accept a resident with higher acuity or hire additional staff as necessary to ensure the needs of all residents are met in a timely manner 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) [redacted]. The team shall jointly determine if the resident should be admitted, readmitted or allowed to remain in the facility. Team approval shall be in writing, signed and dated by all team members and the approval shall be maintained in the resident's record and shall: (a) be based upon an individual service plan (ISP) which identifies the resident's specific needs and addresses the manner that such needs will be met;. a. All DCS will be educated and trained on the use of the [redacted] as to be able to adequately assist resident [redacted] in the event of an emergency. [redacted] training for all DCS to be completed by 09/06/2024. 3. Care coordinators or designee will review all new admissions and determine if ISP is need prior to admission to meet resident needs. Current residents will be assessed every six months during ISP review or upon change of condition. Outside Agencies will be included in ISP meeting for coordination of care and ISP will be documented in reside medical	9/06/2024

			record. 4. Care coordinator or designee will monitor compliance.	

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A 020	Continued From page 1 pursuant to the Incident Reporting Intake, Processing and Training Requirements, 7.1.13 NMAC; (11) the facility ' s bed hold policy; and (12) the admission agreement may be terminated if an appropriate placement is found for the resident, under the following circumstances: (a) there shall be a fifteen (15) day written notice of termination given to the resident or his or her surrogate decision maker, unless the resident requests the termination; (b) the resident has failed to pay for a stay at the facility as defined in the admission agreement; (c) the facility ceases to operate or is no longer able to provide services to the resident; (d) the resident ' s health has improved sufficiently and therefore no longer requires the services of the facility; (e) termination without prior notice is permitted in emergency situations for the following reasons: (i) the transfer or discharge is necessary for the resident's safety and welfare; (ii) the resident's needs cannot safely be met in the facility; or (iii) the safety and health of other residents and staff in the facility are endangered; (13) the facility shall provide a thirty (30) day written notice to residents regarding any changes in the cost or the material services provided; a new or amended admission agreement must be executed whenever services, costs or other material terms are changed; and (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	A 020		

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A 020	Continued From page 2 rule does not apply to hospice residents who have elected to receive the hospice benefit. Conditions or circumstances that usually require continuous nursing care may include but are not limited to the following: (1) ventilator dependency; (2) pressure sores and decubitus ulcers (stage III or IV); (3) intravenous therapy or injections; (4) any condition requiring either physical or chemical restraints; (5) nasogastric tubes; (6) tracheostomy care; (7) residents that present an imminent physical threat or danger to self or others; (8) residents whose psychological or physical condition has declined and placement in the current facility is no longer appropriate as determined by the PCP; (9) residents with a diagnosis that requires isolation techniques; (10) residents that require the use of a Hoyer lift; and (11) ostomy (unless resident is able to provide self care). C. Exceptions to admission, readmission and retention. If a resident requires a greater degree of care than the facility would normally provide or is permitted to provide and the resident wishes to be re-admitted or remain in the facility and the facility wishes to re-admit or retain the resident. The facility shall comply with the following 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.	A 020		

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A 020	Continued From page 3 (2) The team shall jointly determine if the resident should be admitted, readmitted or allowed to remain in the facility. Team approval shall be in writing, signed and dated by all team members and the approval shall be maintained in the resident's record and shall: (a) be based upon an individual service plan (ISP) which identifies the resident's specific needs and addresses the manner that such needs will be met; (b) ensure that if the facility is licensed for more than eight (8) residents and does not have complete fire sprinkler coverage, the facility shall maintain an evacuation rating score of prompt as determined by the fire safety equivalency system (FSES); (c) evaluate and outline how meeting the specific needs of the resident will impact the staff and the other residents; and (d) include an independent advocate such as a certified ombudsman if requested by the resident, the family or the facility. (3) The team recommendation shall be maintained on site in the resident ' s file. (4) When a resident is discharged, the facility shall record where the resident was discharged to and what medications were released with the resident. D. Coordination of care. (1) Assisted living facilities shall have evidence of care coordination on an ISP for all services that are provided in the facility by an outside health 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	A 020		

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A 020	Continued From page 4 provider. [7.8.2.20 NMAC - Rp, 7.8.2.19 NMAC & 7.8.2.20 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.2.8.20 B (10) C (1) (a-c) (2) (a and c) (3) D (1) Based on observation, record review and interview, the facility failed to ensure for 1 (R[redacted] of 1 (R[redacted] residents who require the use of a [redacted] 1. Convened for an exception team meeting for residents requiring the use of a [redacted] a restriction to admission). 2. The team included the facility Administrator and Health Care Professional (if desired, the Resident/Resident's Surrogate Decision Maker, and the [redacted] Clinician (if applicable). 3. The team jointly agreed that the resident should be admitted to the facility, and there was written documentation of the agreement, signed and dated by all the members of the team and: a. Was based upon an Individual Service Plan (ISP) which identified the resident's specific 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 the staff and the other residents living there. 4. The ISP included coordinating care with any outside agencies that are also providing care and services to the resident.	A 020		

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A 020	Continued From page 5 These deficient practices could likely result in the residents identified on the census provided by the Administrator on 02/27/24 to be at risk if: 1. There were not enough staff to meet the needs of residents who require a [redacted] and all the other residents. 2. The staff neglected other residents due to extra time and extra staff required to provide for the higher level of specialized care necessary for the residents requiring [redacted] transfers. 3. A team meeting was not convened and documentation of determination if the needs of the residents who require the use of a [redacted] can be met by the facility. 4. Coordination of care with outside agencies identified on the facility ISP to ensure all residents' needs are being met and the Direct Care Staff (DCS) know what services they need to provide, how often they will be provided, when and where they will be provided, and what services will be provided by the outside agency. The findings are: A. On 02/27/24 at 2:18 pm, during an observation of R [redacted] room, a [redacted] was observed in R [redacted] bathroom shower stall. B. Record review of R [redacted] (admission date [redacted] resident file revealed the following: 1. The Pre-admission Evaluation (dated [redacted] revealed R [redacted] had bruising from the [redacted] but did not reveal whether R [redacted] required a [redacted] upon admission. 2. No documentation of a facility Individual Service Plan (ISP) or evaluation identifying the resident's specific need of requiring the use of a [redacted] for all transfers including: a. How staff will meet R [redacted] specific need? b. How meeting the specific needs of R [redacted] would impact the care and safety of other	A 020		

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A 020	Continued From page 6 residents living at the facility c. The Direct Care Staff's (DCS) ability to provide care and evacuate all residents if a fire or other incident occurred that required evacuation. d. The coordination of care evidence for all services that are provided by an outside health care provider, such as [redacted]. 3. No Team Recommendation document (as required by state regulation) was found in R[redacted] file. 4. The Hospice agency physician's order (dated [redacted] revealed a [redacted] was ordered for [redacted] staff to assist [redacted] at the facility. 5. The Administrator's handwritten care plan notes (dated [redacted]/23) revealed that [redacted] will provide an order to have a [redacted] to use while onsite. 6. [redacted] Care Plan Form (dated [redacted] revealed a [redacted] was ordered for use by [redacted] staff to assist with R[redacted] showers, but there was no documentation or evaluation identifying the resident's specific need of requiring the use of a [redacted] for all transfers including: a. How R[redacted] specific needs would be met. b. How meeting the specific needs of R[redacted] would impact the care and safety of other residents living at the facility c. The facility's Direct Care Staff (DCS) ability to provide care and evacuate all residents if a fire or other incident occurred that required evacuation. C. Record review of R[redacted] facility ISP (dated [redacted]) revealed it was not updated to reflect the resident's specific need for a [redacted] for transfer assistance and did not include documentation of the need for R[redacted] requiring a	A 020		

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A 020	Continued From page 7 [redacted] for: a. R[redacted] transfer assistance from one location to another. b. How R[redacted] needs would be met. c. How meeting the specific needs of R[redacted] would impact the care and safety of other residents living at the facility. d. No coordination of care evidence for all services that are provided in the facility by an outside health care provider, such as hospice or home health providers. D. On 02/27/24 at 2:17 pm, during an interview with R[redacted] stated that staff always use the [redacted] and it is always two (2) people that use it. E. On 02/27/24 at 3:47 pm, during an observation four (4) DCS Transferred R[redacted] from her bed to [redacted] chair as follows: 1. R[redacted] was lifted and placed on top of a [redacted] 2. Care Manager (CM) and DCS #s 2, 6, and 7 each took a corner of the [redacted] and lifted R[redacted] straight up and over to [redacted] recliner to [redacted] of [redacted] bed. F. On 02/27/24 at 3:47 pm, during an interview with CM and DCS #s 2, 6, and 7, they stated that they are not trained to use the [redacted] only [redacted] staff uses it for showers, and that R[redacted] requires a 4-person manual transfer (the resident requires a minimum of 4 people to assist in transfers) for all transfers. G. On 03/05/24 at 1:00 pm, during an interview with the Administrator, she stated that: 1. On 04/14/23, a [redacted] Licensed Practical Nurse (LPN), a [redacted] social worker, the POA, the chaplain, and herself met to discuss ordering	A 020		

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A 020	Continued From page 8 a [redacted] for R[redacted] 2. The Administrator stated that the meeting happened after R[redacted] was admitted [redacted], and she (Administrator) did not document/or include documentation in R[redacted] file regarding: a) Transfer assistance from one location to another. b) How R[redacted] needs would be met. c) How meeting the specific needs of R[redacted] would impact on the care and safety of other residents living at the facility. 3. She confirmed that the [redacted] ISP did not include how the facility DCS would meet the specific needs of transferring R[redacted] or how many DCS would be required to transfer [redacted] manually. 4. She confirmed R[redacted] ISP did not show documentation of any coordination of care.	A 020		
A 022	7 NMAC 8.2.22 Facility Reports, Records, Rules, Policies FACILITY REPORTS, RECORDS, RULES, POLICIES AND PROCEDURES: A. Reports and records. Each facility shall keep the following reports, records, policies and procedures on file at the facility and make them available for review upon request by the licensing authority, residents, potential residents or their surrogate decision makers: (1) fire inspection report; (2) zoning approval; (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	A 022	1. Staff were educated on the Emergency Preparedness plan which includes written emergency plans, policies and procedures for medical emergencies, power failure, fire, or natural disaster; evacuation, persons to be notified, emergency equipment, evacuation routes, refuge areas in place and responsibilities of personnel during emergencies. The binder was placed in a central location accessible to all staff. The plan was reviewed with all staff on 4/9/24 and scheduled to be completed by 9/06/2024: 2. Drills and quarterly review of the emergency preparedness plan will be done with staff and residents to ensure everyone knows what to expect and how to proceed in an emergency. Training completed 4/9/2024. 3. Administrator or designee will review Emergency Preparedness plan every six months or as needed. 4. Administrator or designee will monitor compliance.	9/06/2024

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

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A 022	Continued From page 10 with regard to medications for the residents; and (13) vaccination records for pets in the facility. B. Reports and records. Each facility shall keep the following reports, records, policies and procedures on file at the facility and make them available for review upon request by the licensing authority: (1) a copy of the facility license; (2) employee personnel records, including an application for employment, training records and personnel actions: (a) caregiver criminal history screening documentation pursuant to 7.1.9 NMAC; (b) employee abuse registry documentation pursuant to 7.1.12 NMAC; and (3) a copy of all waivers or variances granted by the licensing authority. C. Rules. Prior to admission to a facility a prospective resident or his or her representative shall be given a copy of the facility rules. Each facility shall have written rules pertaining to resident ' s rights and shall include the following: (1) resident use of tobacco and alcohol; (2) resident use of facility telephone or personal cell phone; (3) resident use of television, radio, stereo and cd; (4) the use and safekeeping of residents ' personal property; (5) meal availability and times; (6) resident use of common areas; (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;	A 022		

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

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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 12 responsibilities; (21) staff training for employees who provide assistance to residents with boarding or alighting from motor vehicles and safe operation of motor vehicles to transport residents; (22) witnessed destruction of unused, outdated or recalled medication by the facility administrator with the consulting pharmacist present; and (23) mealtimes, daily snacks, menus, special diets, resident ' s personal preference for eating alone or in the dining room setting. [7.8.2.22 NMAC - Rp, 7.8.2.23 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.22 A (10) (b) Based on observation, record review and interview, the facility failed to ensure that a the facility had a written Emergency Preparedness Plan (EPP) in the event of a region/area-wide emergency. This deficient practice could likely result in the 36 (R #s 1-36) residents listed on the census provided by the Administrator on 02/27/24, of being at risk of possible harm, injury, or death if the: 1. EPP did not outline evacuation routes. 2. EPP did not list transportation services that are immediately available to transport residents to another location in an emergency. The findings are:	A 022		

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	7098	A. BUILDING: _____ B. WING _____	C 03/05/2024

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A 022	Continued From page 13 A. Record review of the evacuation plan revealed that it did not include the following: 1. Emergency Preparedness Plan for a region/area-wide emergency. 2. Persons to be notified. 2. Evacuation routes. 3. How residents will be immediately transported to another location using transportation services. 4. How residents will be evacuated using what safety equipment, and how will bed-bound residents, including those requiring a Hoyer lift, be evacuated from their rooms. B. On 03/05/24 at 3:00 pm, during an interview with Administrator, she confirmed that the facility's Policy and Procedure Manual did not include a complete Emergency Preparedness plan to included the following: 1. Emergency Preparedness Plan for a region/area-wide emergency. 2. Persons to be notified. 2. Evacuation routes. 3. How residents will be immediately transported to another location using transportation services. 4. How residents will be evacuated using what safety equipment, and how will [redacted] residents, including those requiring a [redacted] be evacuated from their rooms.	A 022		
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	A 026		

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A 026	Continued From page 14 staff observation. (1) The ISP shall detail the services that are provided by the facility as well as the services to be provided by other agencies. (2) The resident evaluation and the ISP shall be reviewed and if needed revised by a licensed practical nurse, registered nurse or a physician extender. (3) The ISP shall be reviewed and or revised at a minimum of every six (6) months or when there is a significant change in the resident ' s health status. B. The ISP shall include the following: (1) a description of identified needs as noted in the resident evaluation; (2) a written description of all services to be provided; (3) who will provide the services; (4) when or how often the services will be provided; (5) how the services will be provided; (6) where the services will be provided; (7) expected goals and outcomes of the services; (8) documentation of the facility ' s determination that it is able to meet the needs of the resident; (9) the level of assistance that the resident will require with activities of daily living and with medications; (10) a crisis prevention/intervention plan when indicated by diagnosis or behavior; and (11) current orders for all medications, including those authorized for PRN usage. [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 B (3, 4, 5, 6. 7, 9)	A 026	1. Training was done with care coordinators on 3/20/24 to make sure the importance of a detailed ISP/Care Plan. How to complete the care plan, what to include and the review/ update process was included in the training. 2. A complete audit of all in house residents ISP's/Care Plans was done by care coordinator(s) or designee All ISP's were reviewed and updated to meet resident needs. ISP will be reviewed every six months per regulation or if there is a change in condition. Facility is moving to electronic charting (EMR) which will have automatic required fields to help prevent missing information. Training done on 3/20/2024. Complete EMR adoption by 7/31/2024. 3. Care Coordinators or designee will review EMR report monthly for upcoming ISP to maintain compliance. 4. Administrator or designee will monitor compliance.	9/06/2024

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A 026	Continued From page 15 Based on observation, record review and interview the facility failed to ensure that the Individual Service Plans (ISPs) for 2 (R #s 2 and [redacted]) of 2 (R #s 2 and [redacted] residents whose plans were reviewed for compliance included: 1. Who will provide services. 2. When or how often the services will be provided. 3. How the services will be provided. 4. Where the services will be provided. 5. Expected goals and outcomes of the services. 6. The level of assistance that the resident will require with activities of daily living (ADLs). These deficient practices could likely result in the residents not receiving appropriate care/services if the Direct Care Staff (DCS) are not aware of who, when, how, how often, and where services will be provided, as well as the residents' expected goals/outcomes of services, and the level of assistance (and equipment) that the resident will require with ADLs. The findings are: R #3: A. Record review of R #3's (admission date [redacted] resident file, revealed that R #3's ISPs dated [redacted]/23 and [redacted]/23, did not include expected goals and outcomes of the services. B. On 03/05/24 at 3:05 pm, during an interview, the Administrator confirmed R #3's ISPs [redacted]/23 and [redacted]/23 did not include goals and outcomes. R [redacted]: C. On 02/27/24 at 2:17 pm, during an observation of R [redacted] room, a [redacted] bathroom.	A 026		

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A 026	Continued From page 16 D. On 02/27/24 at 2:17 pm, during an interview, R #7 stated that the facility DCS always [redacted] E. On 02/27/24 at 3:47 pm, during an observation of R #7 was transferred from [redacted] bedroom chair, four (4) Direct Care Staff (DCS) manually placed R [redacted] (useful device for caregivers who need to assist individuals with limited mobility) and manually lifted [redacted] (used their bodies, rather than a device), to lift [redacted], then over [redacted] chair. F. Record review of R [redacted] (admission date [redacted] resident file, revealed R [redacted] ISPs dated [redacted]/23 and [redacted]23 did not include: 1. Who will provide [redacted] services 2. When or how often [redacted] services will be provided 3. How [redacted] will be provided 4. Where [redacted] will be provided 5. Documentation that the facility will be able to meet the needs of the resident 6. The level of assistance that the resident will require with ADLs. G. On 02/27/24 at 3:47 pm, during an interview, DCS #7 stated that they manually transfer R [redacted], because: 1. The [redacted] only used by outside agency [redacted] staff (not facility staff) to transfer [redacted] (R [redacted] 2. [redacted] staff only come into the facility three (3) times per week. 3. Four (4) person assistance is normally required to manually lift R [redacted] for transfers. if [redacted] staff are not onsite.	A 026		

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A 026	Continued From page 17 H. On 03/04/24 at 1:43 pm, during an interview with the administrator, she confirmed: 1. DCS do not transfer R[redacted] using the [redacted]r lift because DCS have not been trained. Instead, they transferred[redacted] manually. 2. Four (4) staff members are responsible for manually transferring R[redacted] 3. Their emergency preparedness plan does not include an evacuation plan, documentation on evacuating residents that require four persons transfer assistance. I. On 03/05/24 at 3:05 pm, during an interview, the Administrator confirmed R[redacted] ISPs dated [redacted] and [redacted] did not include who, when, how often, how, or where [redacted] services will be provided to R[redacted] The ISP did not contain any documentation that the facility will be able to meet the needs, and the level of assistance that the resident will require with ADLs.	A 026		
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	A 034		

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A 034	Continued From page 18 in a locked room, as approved by the board of pharmacy and the key shall be in the care of the administrator or designee. (2) Internal medication shall be kept separate from external medications. Drugs to be taken by mouth shall be separated from all other delivery forms. (3) A separate, locked refrigerator shall be provided by the facility for medications. The refrigerator temperature shall be kept in compliance with the state board of pharmacy requirements for medications. (4) All medications, including non-prescription medications, shall be stored in separate compartments for each resident and all medications shall be labeled with the resident's name. (5) A resident may be permitted to keep his or her own medication in a locked compartment in his or her room for self-administration, if the physician's order deems it appropriate. (6) The facility shall not require the residents to purchase medications from any particular pharmacy. (7) Medical gases (oxygen) and equipment used for the administration of inhalation therapy and for resuscitative purposes shall comply with the 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;	A 034	1. Education was completed with care coordinators and Administrators on 3/20/24 and then with all staff on 4/5/24 on the appropriate action to take when a resident refuses a medication, is out of a medication, or the family refuses to replenish the medication. 2. Detailed documentation will be completed for every medication exception. Utilizing EMR system Medication will be reviewed daily by the care coordinator or designee and weekly by the administrator or designee As appropriate, residents' family and/or their physician(s) will be contacted for any medication refusal or refill issue that exceeds three medication passes. Training was completed on 4/5/24 to staff who Pass medication. 3. Care coordinator or designee will continue to audit EMR weekly for four weeks or until 90% compliance is achieved for medication exceptions and correct as needed. 4. Care coordinators or designee will monitor compliance.	

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A 034	Continued From page 19	A 034		

(f) the signature of the person assisting with delivery of the medication; and
(g) the balance of medication remaining.
(9) Any remaining medication discontinued by a physician ' s order, or upon discharge or death of the resident shall be inventoried and moved to a separate locked storage container. Such discontinued medications shall be destroyed upon the next quarterly visit by the consulting pharmacist in accordance with 16.19.11.10 NMAC.
(10) The record of medication destruction shall be signed by the administrator or designee and the pharmacist and shall be kept on file at the facility.
B. Consulting pharmacist. The facility shall maintain records demonstrating that the consulting pharmacist provides the following oversight and guidance.
(1) Reviews the medication regimen as needed, but at least quarterly/every three (3) months, to determine that all medications and records are accurate and current. All irregularities shall be reported to the administrator of the facility and these irregularities shall be resolved by the administrator within seventy-two (72) hours.
(2) A system of records of receipt and disposition 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

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A 034	Continued From page 20 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 Based on record review, observation, and interview, the facility failed to ensure for 2 (R #s [redacted] and [redacted]) of 2 (R #s [redacted] and [redacted] residents whose medications were reviewed for compliance, that: their medications were available at the facility for use by the resident. These deficient practices could likely result in the residents to be at risk of harm, injury, or death if prescribed medications are not available to be taken when needed. The findings are: R [redacted] A. Record review of Complaint Intake [redacted] stated, Resident/Patient/Client Neglect: Staff is unresponsive, unprofessional, as well as disrespectful. [redacted] on [redacted] (R #3's) [redacted], R [redacted] not bathing, linens not changed, R [redacted] not being moved or repositioned. B. Record review of R [redacted] Physician's Orders revealed the following medications were ordered: 1. On [redacted] /23, [redacted] 2. On [redacted] /22 , [redacted] 3. On [redacted] /22, [redacted]	A 034		

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A 034	Continued From page 21 [redacted] 4. On [redacted]/22, [redacted] C. Record review of R [redacted] Medication Administration Record (MAR) dated [redacted]/23 through [redacted]/23, revealed the following medications were unavailable to R [redacted] and listed the following exception notations: 1. From [redacted]/23 through [redacted]/23, [redacted] unavailable, Med (Medication) needs to be re-ordered (61 days/dosages missed). 2. From [redacted]/23 through [redacted]/23 , [redacted] unavailable, Med needs to be re-ordered (61 days/dosages missed). 3. From [redacted]/23 through [redacted]/23, [redacted] unavailable, Med needs to be re-ordered (61 days/dosages missed). 4. From [redacted]/23 through [redacted]/23, [redacted] unavailable, Med needs to be re-ordered (4 days/dosages missed). D. On 03/06/24 at 10:35 am, during an interview, the Administrator confirmed that the following physician-ordered medications were not available for R [redacted] to take because the facility had not ordered the medication: 1. From [redacted]/23 through [redacted]/24, [redacted] unavailable to R [redacted] (61 days/dosages missed). 2. From [redacted]1/23 through [redacted]/23 , [redacted]), unavailable to [redacted] (61 days/dosages missed). 3. From [redacted]/23 through [redacted]/23, [redacted] unavailable to R [redacted] 4. From [redacted]/23 through [redacted]/23, [redacted]	A 034		

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A 034	Continued From page 22 [redacted] unavailable to R[redacted] E. On 03/06/24 at 11:22 am, during an interview, R[redacted] Pharmacist, stated the following risks could happen to R[redacted] because[redacted] missed the following medications: 1. [redacted] Missing this medication could cause R[redacted] 2. [redacted] Missing this medication could impact R[redacted] 3. [redacted] Missing this medication could cause [redacted] If the Direct Care Staff (DCS) felt there was a concern of [redacted] with the maintenance regimen, they should contact R[redacted] doctor to change the order. 4. [redacted] R[redacted] and it is a maintenance medication for [redacted]. Missing this medication could cause difficulty breathing and respiratory problems for R[redacted] R[redacted] F. Record review of R[redacted] Physician's Orders revealed the following medications were ordered as follows: 1. On 02/20/24, [redacted]	A 034		

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A 034	Continued From page 23 [redacted] 2. On 02/20/24, [redacted] G. Record review of R[redacted] MAR dated [redacted]/24 through [redacted]/24, revealed the following medications were unavailable for R[redacted] 1. From [redacted]/24 through [redacted]/24, [redacted] Meds need to be re-ordered (10 days/19 dosages missed). 2. From [redacted]/24 through [redacted]/24, [redacted] Meds need to be re-ordered (9 days/dosages missed). H. On 03/06/24 at 10:35 am, during an interview, the Administrator confirmed the following physician ordered medications were not available for R[redacted] to take because the medications had not been ordered: 1. [redacted] (10 days/19 dosages missed). 2. [redacted] (9 days/dosages missed). I. On 03/07/24 at 11:43 am, during an interview with R[redacted] Physician, she revealed the following risks could happen to R[redacted] because [redacted] missed the following medications: 1. [redacted] The risk of missing this medication is that the infection will continue, and you will eventually get	A 034		

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A 034	Continued From page 24 [redacted] 2. [redacted]. The Medication needs to be re-ordered. If/when R[redacted] becomes [redacted], there is risk of [redacted] if this medication is not on hand.	A 034		
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	A 038	1. Staff and residents were educated on safety and storing items appropriately to reduce hazards. Staff moved residents personal items to be stored in a hazard free manner. 2. Staff will help put away residents personal belongings to keep facility hazard free. Overstock will be used and encouraged staff, residents, and family.to keep resident spaces tidy and fee of hazards. Training Completed 3/5/2024. 3. Administrator or designee will complete facility rounds weekly for storage of items in resident rooms. 4. Administrator or designee will monitor compliance.	

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	7098	A. BUILDING: _____ B. WING _____	C 03/05/2024

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SANDIA VIEW FOUNTAIN HILL	4551 VISTA FUENTE RD NW ALBUQUERQUE, NM 87114

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 038	Continued From page 25 by: 7.8.2.38 Based on observation and interview, the facility failed to ensure that resident bathrooms were kept clean, orderly, and free of safety hazards. These deficient practices could likely result in the 36 (R #s 1-36) residents listed on the census provided by the Administrator on 02/27/24, to be at risk of harm, injury, or death if residents were to accidentally trip or be trapped under stacked boxes if they were to accidentally trip or bump into supplies stacked in the bathrooms and showers that posed as a safety hazard. The findings are: A. On 03/01/24 at 8:45 am, during observation of Room [redacted], access to parts of the bathroom were obstructed by the following items and posed a safety hazard to the residents: 1. Six (6) large boxes of supplies and other loose items were stacked/stored across from the toilet and behind the bathroom door. 2. A wheelchair was stored behind a shower chair, partially in and outside of the shower stall, blocking access to the sink cabinets. 3. A box, a wash tub, and two (2) wheelchair footrests were stacked between the shower and the sink, blocking the sink cabinets and part of the sink counter. 4. A walker was stored between the toilet and the sink. 5. The sink counter was cluttered with toiletries and a box of unidentified items. B. On 03/01/24 at 9:05 am, during observation of R[redacted] access to parts of the bathroom was obstructed by the following items and posed as a safety hazard to the residents:	A 038		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	7098	A. BUILDING: _____ B. WING _____	C 03/05/2024

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A 038	Continued From page 26 1. Toilet tank had underwear products stacked on it (could fall into the toilet or on the resident as the resident sits on the toilet). 2. Two walkers were stored in front of and beside the toilet. 3. The sink was covered with supplies, including underwear, a plastic bag, paints, and several grooming products. C. On 03/01/24 at 9:07 am, during an observation of R[redacted] bathroom, it was observed that the following items obstructed access to parts of the bathroom and posed as a safety hazard (photos taken): 1. The shower stall used as storage contained medical devices and an easel, which completely blocked access to the shower stall. 2. A portable shower chair blocked toilet access. D. On 03/01/24 at 9:30 am, during an interview, the Care Coordinator (CC) confirmed that items stored in the bathroom were obstructing access to the toilet, the shower and the sink and the obstructions were a safety hazard to residents requiring the access and she (CC) stated that: 1. R[redacted] reside in a [redacted] room, they [redacted] bathroom. 2. R[redacted] to and from the bathroom using[redacted] 3. The facility stores residents' supplies in their bathrooms because it does not have a storage closet. 4. The bathrooms are disorganized, cluttered, and hazardous. 5. Most showers are inaccessible because they contain supplies stored within. E. On 03/01/24 at 9:45 am, the Administrator confirmed that the facility, lacked a storage room,	A 038		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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A 038	Continued From page 27 when built, so supplies were stored in the bathrooms.	A 038		