

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 7154	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 10/12/2023
NAME OF PROVIDER OR SUPPLIER SINGING ARROW AFH LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 12904 PIRU BLVD SE ALBUQUERQUE, NM 87123		
(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 an Initial survey completed on [REDACTED]/23 for the state requirements of 7 NMAC 8.2, Regulations for Assisted Livings for Adults. Resident Census is [REDACTED]	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; (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:	A 016	WHAT: DOH CLEARANCE LETTER FOR DIRECT CARE STAFF WHEN: UPON HIRING EMPLOYEES WILL HAVE BACKGROUND CHECKS HOW: NEW EMPLOYEES ARE TO RECEIVE CLEARANCE LETTER PRIOR PROVIDING DIRECT CARE UNSUPERVISED WHO: ADMINISTRATOR WILL RUN REQUIRE STATE BACKGROUND CLEARANCE Administratpr has the fingerprint and backgrnd check cpmpleted and will be submitting the dpcumentatign tp CCHSP.	[REDACTED]/2023

Division of Health Improvement

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Ana Papadine

PROVIDER

10/27/23

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 7154	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 10/12/2023
NAME OF PROVIDER OR SUPPLIER SINGING ARROW AFH LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 12904 PIRU BLVD SE ALBUQUERQUE, NM 87123		
(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 016	Continued From page 1 (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 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]	A 016		

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 7154	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 10/12/2023
NAME OF PROVIDER OR SUPPLIER SINGING ARROW AFH LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 12904 PIRU BLVD SE ALBUQUERQUE, NM 87123		
(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 016	Continued From page 2 This REQUIREMENT is not met as evidenced by: 7.8.2.16 B (3) (7) Refer to 7.1.12 EMPLOYEE ABUSE REGISTRY 7.1.12.8 REGISTRY ESTABLISHED; PROVIDER INQUIRY REQUIRED: Upon the effective date of this rule, the department has established and maintains an accurate and complete electronic registry that contains the name, date of birth, address, social security number, and other appropriate identifying information of all persons who, while employed by a provider, have been determined by the department, as a result of an investigation of a complaint, to have engaged in a substantiated registry-referred incident of abuse, neglect or exploitation of a person receiving care or services from a provider. Additions and updates to the registry shall be posted no later than two (2) business days following receipt. Only department staff designated by the custodian may access, maintain and update the data in the registry. A. Provider requirement to inquire of registry. A provider, prior to employing or contracting with an employee, shall inquire of the registry whether the individual under consideration for employment or contracting is listed on the registry. B. Prohibited employment. A provider may not employ or contract with an individual to be an employee if the individual is listed on the registry as having a substantiated registry-referred incident of abuse, neglect or exploitation of a person receiving care or services from a provider. C. Applicant's identifying information required. In making the inquiry to the registry prior to employing or contracting with an employee, the	A 016			

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 7154	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 10/12/2023
NAME OF PROVIDER OR SUPPLIER SINGING ARROW AFH LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 12904 PIRU BLVD SE ALBUQUERQUE, NM 87123		
(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 016	Continued From page 3 provider shall use identifying information concerning the individual under consideration for employment or contracting sufficient to reasonably and completely search the registry, including the name, address, date of birth, social security number, and other appropriate identifying information required by the registry. D. Documentation of inquiry to registry. The provider shall maintain documentation in the employee's personnel or employment records that evidences the fact that the provider made an inquiry to the registry concerning that employee prior to employment. Such documentation must include evidence, based on the response to such inquiry received from the custodian by the provider, that the employee was not listed on the registry as having a substantiated registry-referred incident of abuse, neglect or exploitation. E. Documentation for other staff. With respect to all employed or contracted individuals providing direct care who are licensed health care professionals or certified nurse aides, the provider shall maintain documentation reflecting the individual's current licensure as a health care professional or current certification as a nurse aide. F. Consequences of noncompliance. The department or other governmental agency having regulatory enforcement authority over a provider may sanction a provider in accordance with applicable law if the provider fails to make an appropriate and timely inquiry of the registry, or fails to maintain evidence of such inquiry, in connection with the hiring or contracting of an employee; or for employing or contracting any person to work as an employee who is listed on the registry. Such sanctions may include a directed plan of correction, civil monetary penalty not to exceed five thousand dollars (\$5000) per	A 016		

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 7154	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 10/12/2023
NAME OF PROVIDER OR SUPPLIER SINGING ARROW AFH LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 12904 PIRU BLVD SE ALBUQUERQUE, NM 87123		
(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 016	Continued From page 4 instance, or termination or non-renewal of any contract with the department or other governmental agency. [7.1.12.8 NMAC - N, 01/01/2006] 7.1.9.8 CAREGIVER AND HOSPITAL CAREGIVER EMPLOYMENT REQUIREMENTS: ... D. Application: In order for a nationwide criminal history record to be obtained and processed, the following shall be submitted to the department on forms provided by the department. (1) A form containing personal identification which has a photograph of the person and which meets the requirements for employment eligibility in accordance with the immigration and nationality act as amended. A reasonable xerographic copy of a drivers license photograph will suffice under Subsection D of 7.1.9.8 NMAC. (2) A signed authorization for release of information form. (3) Three (3) complete sets of readable fingerprint cards or other department approved media acceptable to the Department of Public Safety and the Federal Bureau of Investigation submitted using black ink. (4) The fee specified by the department for the nationwide and statewide criminal history screening investigation shall not exceed seventy-four (\$74) dollars. Of which, twenty-four (\$24) dollars shall be applied for the federal bureau of investigation nationwide criminal history screening, seven (\$7) dollars shall be applied for the statewide criminal history screening. The remaining application fee shall be applied to cover costs incurred by the Department to support activities required by the Act and these rules. The fees will not be applied to any other activity or expense undertaken by the Department.	A 016		

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 7154	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 10/12/2023
NAME OF PROVIDER OR SUPPLIER SINGING ARROW AFH LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 12904 PIRU BLVD SE ALBUQUERQUE, NM 87123		
(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 016	Continued From page 5 ... E. Fees: The federal bureau of investigation has a mandatory processing fee with no exceptions. The Department and Department of Public Safety impose a state processing and administrative fee. The fee payment must accompany the fingerprint application, or otherwise be credited to the department prior to or at the same time with the department's receipt of the application documents. The manner of payment of the fee is by bank cashier check or money order payable to the New Mexico Department of Health or other method of funds transfer acceptable to the department. Business checks will be accepted unless the business tendering the check has previously tendered a check to the department unsupported by sufficient funds. Neither cash nor personal checks will be accepted. The fee may be paid by the care provider or by the applicant, caregiver or hospital caregiver. The department will set a fee in addition to the fees imposed by Department of Public Safety and the Federal Bureau of Investigation that will fully and completely cover costs incurred by the department to support activities required by the act and these rules. The fees will not be applied to any other activity or expense undertaken by the department. F. Timely Submission: Care providers shall submit all fees and pertinent application information for all individuals who meet the definition of an applicant, caregiver or hospital caregiver as described in Subsections B, D and K of 7.1.9.7 NMAC, no later than twenty (20) calendar days from the first day of employment or effective date of a contractual relationship with the care provider. G. Maintenance of Records: Care providers shall maintain documentation relating to all employees and contractors evidencing compliance with the	A 016		

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 7154	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 10/12/2023
NAME OF PROVIDER OR SUPPLIER SINGING ARROW AFH LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 12904 PIRU BLVD SE ALBUQUERQUE, NM 87123		
(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 016	Continued From page 6 act and these rules. (1) During the term of employment, care providers shall maintain evidence of each applicant, caregiver or hospital caregiver's clearance, pending reconsideration, or disqualification. (2) Care providers shall maintain documented evidence showing the basis for any determination by the care provider that an employee or contractor performs job functions that do not fall within the scope of the requirement for nationwide or statewide criminal history screening. A memorandum in an employee's file stating "This employee does not provide direct care or have routine unsupervised physical or financial access to care recipients served by [name of care provider]," together with the employee's job description, shall suffice for record keeping purposes. Based on record review and interview, the facility failed to ensure that the Direct Care Staff (DCS): 1. Were cleared by the Employee Abuse Registry (EAR) prior to hire. 2. Application and fingerprints were submitted to the Caregiver Criminal History Screening Program (CCHSP) within 20 days of hire. 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, if residents are being provided care by staff who may have a previous history of abusing, neglecting, and/or exploiting residents and may be a convicted felon. The findings are: A. Record review of the Administrators' employee file, revealed at the time of this survey:	A 016		

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 7154	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 10/12/2023
NAME OF PROVIDER OR SUPPLIER SINGING ARROW AFH LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 12904 PIRU BLVD SE ALBUQUERQUE, NM 87123		
(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 016	Continued From page 7 1. The Administrator's EAR clearance had not been completed. 2. The Administrator's application and fingerprinting had not been completed or submitted to CCHSP. B. On [REDACTED] 23 at 11:25 am, during an interview, the Administrator confirmed her: 1. EAR clearance was not completed. 2. Application and fingerprints had not been completed or submitted to CCHSP.	A 016			
A 019	7 NMAC 8.2.19 Staffing Ratios STAFFING RATIOS: The following staffing levels are the minimum requirements. A. The facility shall employ the sufficient number of staff to provide the basic care, resident assistance and the required supervision based on the assessment of the residents' needs. (1) During resident waking hours, facilities shall have at least one (1) direct care staff person on duty and awake at all times for each fifteen (15) residents. (2) During resident sleeping hours, facilities with fifteen (15) or fewer residents shall have at least one (1) direct care staff person on duty, awake and responsible for the care and supervision of the residents. (3) During resident sleeping hours, facilities with sixteen (16) to thirty (30) residents shall have at least one (1) direct care staff person on duty and awake at all times and at least one (1) additional staff person available on the premises. (4) During resident sleeping hours, facilities with thirty-one (31) to sixty (60) residents shall have at least two (2) direct care staff persons on duty and awake at all times and at least one (1) additional staff person immediately available on the	A 019	WHAT: NIGHTLY AWAKE STAFFING WHEN: EVERY NIGHT A STAFF IS AWAKE TO CARE FOR RESIDENTS HOW: FACILITY IS TO MAINTAIN ONE (1) EMPLOYEE AWAKE AT NIGHT HOURS TO SUPERVISED RESIDENTS WHO: ADMINISTRATOR TO KEEP 24 HRS STAFF AWAKE TO SUPERVISE RESIDENTS	[REDACTED] /2023	

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 7154	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 10/12/2023
NAME OF PROVIDER OR SUPPLIER SINGING ARROW AFH LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 12904 PIRU BLVD SE ALBUQUERQUE, NM 87123		
(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 019	Continued From page 8 premises. (5) During resident sleeping hours, facilities with more than sixty-one (61) residents shall have at least three (3) direct care staff persons on duty and awake at all times and one (1) additional staff person immediately available on the premises for each additional thirty (30) residents or fraction thereof in the facility. B. Upon request of the department, the facility shall provide the staffing ratios per each twenty-four (24) hour day for the past thirty (30) days. [7.8.2.19 NMAC - Rp, 7.8.2.18 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.19 A (1-2) Based on record review and interview, the facility failed to ensure that for facilities with fewer than 15 residents, that there was at least one Direct Care Staff (DCS) on duty, awake, and able to provide care and supervision to the residents during waking and sleeping hours. This deficient practice could likely negatively effect the safety and welfare of the [REDACTED] residents identified on the resident census provided by the Administrator on [REDACTED]/23, to be at risk of harm, injury if there is not adequate staffing available to assist the residents. The findings are: A. Record review of the facility staff census revealed there was only one employed staff on duty for the day and night shifts, working the 24 hours a day (the Administrator). B. On [REDACTED]/23 at 9:19 am, during an interview, the Administrator confirmed that on the night shift	A 019		

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 7154	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 10/12/2023
NAME OF PROVIDER OR SUPPLIER SINGING ARROW AFH LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 12904 PIRU BLVD SE ALBUQUERQUE, NM 87123			
(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 019	Continued From page 9 there is not a staff that is awake and on duty to provide care for the residents. The Administrator stated she was on the facility premises 24-hours per day and does sleep during the night (very little), but wakes up to help residents when needed.	A 019			
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	A 020	WHAT: COMPLETION OF RESIDENT ADMISSION AGREEMENT Admission packets have been created for each client in the facility. The binders provide personal information, current photos, and care plans. Each client's binder provides all the facility information as well as medical needs and medication needs. Each binder contains all information about the contracts and care. If need be, there will also be a copy of incident reports. WHEN: UPON ARRIVAL RESIDENTS FILE ARE TO BE COMPLETE AND HOW: ADMISSIONS FORMS CREATED ADDRESSING STATE REQUIREMENTS WHO: ADMINISTRATOR IS TO SUPERVISE AND FOLLOW ADMISSIONS STATE REQUIREMENTS	[REDACTED] 2023	

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 7154	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 10/12/2023
NAME OF PROVIDER OR SUPPLIER SINGING ARROW AFH LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 12904 PIRU BLVD SE ALBUQUERQUE, NM 87123		
(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 020	Continued From page 10 (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 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	A 020		

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 7154	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 10/12/2023
NAME OF PROVIDER OR SUPPLIER SINGING ARROW AFH LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 12904 PIRU BLVD SE ALBUQUERQUE, NM 87123		
(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 020	Continued From page 11 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. (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	A 020		

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 7154	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 10/12/2023
NAME OF PROVIDER OR SUPPLIER SINGING ARROW AFH LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 12904 PIRU BLVD SE ALBUQUERQUE, NM 87123		
(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 020	Continued From page 12 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 (FSSES); (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		

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 7154	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 10/12/2023
NAME OF PROVIDER OR SUPPLIER SINGING ARROW AFH LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 12904 PIRU BLVD SE ALBUQUERQUE, NM 87123		
(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 020	Continued From page 13 This REQUIREMENT is not met as evidenced by: 7.8.2.20 A(1-3, 5-8, 10-12) (a-e, i, ii, iii) (13) Based on record review and interview, the facility failed to ensure for [REDACTED] residents whose Admission Agreements were reviewed for compliance, that they included the following information: 1. The parties to the agreement 2. The program narrative 3. The facility's rules 4. A refund provision in case of death, transfer, voluntary or involuntary discharge 5. Information to formulate advance directives 6. A written description of the legal rights of the residents translated into another language, if necessary 7. The facility's staffing ratio 8. Notification of rights and responsibilities pursuant to the Incident Reporting Intake, Processing and Training Requirements, 7.1.13 NMAC 9. The facility's bed hold policy 10. 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;	A 020		

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 7154	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 10/12/2023
NAME OF PROVIDER OR SUPPLIER SINGING ARROW AFH LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 12904 PIRU BLVD SE ALBUQUERQUE, NM 87123		
(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 020	Continued From page 14 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 11. 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 This deficient practice could likely result in the residents not being aware of the services provided, facility policies, and resident rights. The findings are: A. Record review of R #2's Admission Agreement dated [REDACTED] revealed that it did not include: 1. The parties to the agreement 2. The program narrative 3. The facility's rules 4. The refund provision in case of death, transfer, voluntary or involuntary discharge 5. Information to formulate advance directives 6. A written description of the legal rights of the residents translated into another language, if necessary 7. The facility's staffing ratio 8. Notification of rights and responsibilities pursuant to the Incident Reporting Intake, Processing and Training Requirements, 7.1.13 NMAC 9. The facility's bed hold policy 10. The admission agreement may be terminated if an appropriate placement is found for the resident, under the following circumstances:	A 020		

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 7154	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 10/12/2023
NAME OF PROVIDER OR SUPPLIER SINGING ARROW AFH LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 12904 PIRU BLVD SE ALBUQUERQUE, NM 87123		
(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 020	Continued From page 15 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 11. 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. B. On [REDACTED]/23 at 11:25 am, during an interview, the Administrator confirmed the Admission agreement for R #2 did not include: 1. The parties to the agreement 2. The program narrative 3. The facility's rules 4. The refund provision in case of death, transfer, voluntary or involuntary discharge 5. Information to formulate advance directives 6. A written description of the legal rights of the residents translated into another language, if necessary 7. The facility's staffing ratio 8. Notification of rights and responsibilities	A 020			

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 7154	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 10/12/2023
NAME OF PROVIDER OR SUPPLIER SINGING ARROW AFH LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 12904 PIRU BLVD SE ALBUQUERQUE, NM 87123			
(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 020	Continued From page 16 pursuant to the Incident Reporting Intake, Processing and Training Requirements, 7.1.13 NMAC 9. The facility's bed hold policy 10. 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 11. 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.	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	A 021	WHAT: RESIDENT FILES PROPERLY ORGANIZATION WHEN: UPON RESIDENT ARRIVAL HOW: ORGANIZED RESIDENT FILE FOR EASY ACCESS AND INFORMATION REQUIRED WHO: ADMINISTRATOR WILL ORGANIZE, UPDATE AND MAINTAIN RESIDENT FILE	2023	

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 7154	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 10/12/2023
NAME OF PROVIDER OR SUPPLIER SINGING ARROW AFH LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 12904 PIRU BLVD SE ALBUQUERQUE, NM 87123		
(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 021	Continued From page 17 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 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;	A 021		

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 7154	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 10/12/2023
NAME OF PROVIDER OR SUPPLIER SINGING ARROW AFH LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 12904 PIRU BLVD SE ALBUQUERQUE, NM 87123		
(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 021	Continued From page 18 (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 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	A 021			

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 7154	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 10/12/2023
NAME OF PROVIDER OR SUPPLIER SINGING ARROW AFH LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 12904 PIRU BLVD SE ALBUQUERQUE, NM 87123		
(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 021	Continued From page 19 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 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 (1-5) (d) (7-8) (10) Based on record review and interview, the facility failed to ensure for [REDACTED] residents that each resident record included: 1. Admission agreement records. 2. Resident evaluation forms, completed within fifteen (15) days prior to admission and updated at a minimum of every six (6) months. 3. Current Individual Service Plans (ISPs),	A 021		

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 7154	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 10/12/2023
NAME OF PROVIDER OR SUPPLIER SINGING ARROW AFH LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 12904 PIRU BLVD SE ALBUQUERQUE, NM 87123		
(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 021	Continued From page 20 completed within ten (10) calendar days of admission and updated at a minimum of every six (6) months. 4. The physical examination report completed within the past six (6) months, by a primary care physician, a nurse practitioner or a physician's assistant. 5. A recent photograph of the resident 6. Entries by direct care staff, appropriate health care professionals and others authorized to care for the resident. 7. 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 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. 8. Progress notes completed by any contract agency. These deficient practices could likely negatively affect the health, safety, and welfare of the residents, if their information is not readily available, or if the facility does not include the required information in their files. The findings are: The findings for R #1: A. Record review of R #1's (admission date [REDACTED] resident file, revealed that the following was not completed when the facility changed ownership in April 2022 and included in the resident file: 1. Admission agreement records.	A 021			

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 7154	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 10/12/2023
NAME OF PROVIDER OR SUPPLIER SINGING ARROW AFH LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 12904 PIRU BLVD SE ALBUQUERQUE, NM 87123		
(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 021	Continued From page 21 2. Resident evaluation forms, completed within fifteen (15) days prior to admission and updated at a minimum of every six (6) months. 3. Current Individual Service Plans (ISPs), completed within ten (10) calendar days of admission and updated at a minimum of every six (6) months. 4. The physical examination report completed within the past six (6) months, by a primary care physician, a nurse practitioner or a physician's assistant. 5. A recent photograph of the resident 6. Entries by direct care staff, appropriate health care professionals and others authorized to care for the resident. 7. 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 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. 8. Progress notes completed by any contract agency (hospice, home health, nursing). B. On [REDACTED] 23 at 11:30 am, during an interview, the Administrator confirmed R #1's resident file did not include the following: 1. Admission agreement records. 2. Resident evaluation forms, completed within fifteen (15) days prior to admission and updated at a minimum of every six (6) months. 3. Current Individual Service Plans (ISPs), completed within ten (10) calendar days of admission and updated at a minimum of every six (6) months.	A 021		

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 7154	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 10/12/2023
NAME OF PROVIDER OR SUPPLIER SINGING ARROW AFH LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 12904 PIRU BLVD SE ALBUQUERQUE, NM 87123		
(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 021	Continued From page 22 4. The physical examination report completed within the past six (6) months, by a primary care physician, a nurse practitioner or a physician's assistant. 5. A recent photograph of the resident 6. Entries by direct care staff, appropriate health care professionals and others authorized to care for the resident. 7. 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 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. 8. Progress notes completed by any contract agency. The findings for R #2: C. Record review of R #2 (admission date [REDACTED]) resident file revealed that the following was not completed when the facility changed ownership in April 2022 and included in the resident file: 1. Resident evaluation forms, completed within fifteen (15) days prior to admission and updated at a minimum of every six (6) months. 2. Current Individual Service Plans (ISPs), completed within ten (10) calendar days of admission and updated at a minimum of every six (6) months. 3. The physical examination report completed within the past six (6) months, by a primary care physician, a nurse practitioner or a physician's assistant.	A 021		

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 7154	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 10/12/2023
NAME OF PROVIDER OR SUPPLIER SINGING ARROW AFH LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 12904 PIRU BLVD SE ALBUQUERQUE, NM 87123		
(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 021	Continued From page 23 4. A recent photograph of the resident 5. Entries by direct care staff, appropriate health care professionals and others authorized to care for the resident. 6. 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 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. 7. Progress notes completed by any contract agency (hospice, home health, nursing). D. On [REDACTED]/23 at 11:31 am, during an interview, the Administrator confirmed R #2's resident file did not include the following: 1. Resident evaluation forms, completed within fifteen (15) days prior to admission and updated at a minimum of every six (6) months. 2. Current Individual Service Plans (ISPs), completed within ten (10) calendar days of admission and updated at a minimum of every six (6) months. 3. The physical examination report completed within the past six (6) months, by a primary care physician, a nurse practitioner or a physician's assistant. 4. A recent photograph of the resident 5. Entries by direct care staff, appropriate health care professionals and others authorized to care for the resident. 6. 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	A 021		

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 7154	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 10/12/2023
NAME OF PROVIDER OR SUPPLIER SINGING ARROW AFH LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 12904 PIRU BLVD SE ALBUQUERQUE, NM 87123		
(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 021	Continued From page 24 indicate a need for alternative placement or medical attention and entries reflecting appropriate follow-up; the maintenance of such 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. 7. Progress notes completed by any contract agency. The findings for R #3: E. Record review of R #3 (admission date [REDACTED]) resident file revealed that the following was not completed when the facility changed ownership in April 2022 and included in the resident file: 1. Admission agreement records. 2. Resident evaluation forms, completed within fifteen (15) days prior to admission and updated at a minimum of every six (6) months. 3. Current Individual Service Plans (ISPs), completed within ten (10) calendar days of admission and updated at a minimum of every six (6) months. 4. The physical examination report completed within the past six (6) months, by a primary care physician, a nurse practitioner or a physician's assistant. 5. A recent photograph of the resident 6. Entries by direct care staff, appropriate health care professionals and others authorized to care for the resident. 7. 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		

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 7154	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 10/12/2023
NAME OF PROVIDER OR SUPPLIER SINGING ARROW AFH LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 12904 PIRU BLVD SE ALBUQUERQUE, NM 87123		
(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 021	Continued From page 25 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. 8. Progress notes completed by any contract agency (hospice, home health, nursing). F. On [REDACTED]/23 at 11:32 am, during an interview, the Administrator confirmed R #3's resident file did not include the following: 1. Admission agreement records. 2. Resident evaluation forms, completed within fifteen (15) days prior to admission and updated at a minimum of every six (6) months. 3. Current Individual Service Plans (ISPs), completed within ten (10) calendar days of admission and updated at a minimum of every six (6) months. 4. The physical examination report completed within the past six (6) months, by a primary care physician, a nurse practitioner or a physician's assistant. 5. A recent photograph of the resident 6. Entries by direct care staff, appropriate health care professionals and others authorized to care for the resident. 7. 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 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. 8. Progress notes completed by any contract agency.	A 021		

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 7154	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 10/12/2023
NAME OF PROVIDER OR SUPPLIER SINGING ARROW AFH LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 12904 PIRU BLVD SE ALBUQUERQUE, NM 87123		
(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 035	Continued From page 26	A 035		
A 035	7 NMAC 8.2.35 Medication MEDICATIONS: Administration of medications or staff assistance with self-administration of medications shall be in accordance with state and federal laws. No medications, including over-the-counter medications, PRN (when needed) medications, or treatment shall be started, changed or discontinued by the facility without an order from the physician, physician assistant or nurse practitioner and with entry into the resident's record. A. State board of nursing licensed or certified health care professionals are responsible for the administration of medications. Administration may only be performed by these individuals. B. Facility staff may assist a resident with the self-administration of medications if written consent by the resident is given to the administrator of the facility or the administrator's designee. If the resident is incapable of giving consent, the surrogate decision maker named in accordance with New Mexico law may give written consent for assistance with self-administration of medications. All staff that assist with self-administration of medications shall have successfully completed a state approved assistance with self-administration of medication training program or be licensed or certified by the state board of nursing. C. PRN (pro re nada) medication. (1) Physician or physician extender's orders for PRN medications shall clearly indicate the circumstances in which they are to be used, the number of doses that may be given in a 24-hour period and indicate under what circumstances the primary care practitioner (PCP) is to be notified. (2) The utilization of PRN medications shall be reviewed routinely. Frequent or escalating use of	A 035	WHAT: ASSISTANCE WITH MEDICATION TRAINING Administratpr has obtained a medication administration certificate as well as hiring an LPN on the staff. Medications are on both a scheduled and PRN basis. WHEN: STAFF, UPON HIRING, IS TO RECEIVE ASSISTANCE WITH MEDICATIONS TRAINING HOW: TRAINING TO BE COMPLETED PRIOR ASSISTING RESIDENTS WHO: ADMINISTRATOR TO ENROLL STAFF FOR TRAINING	██████/2023

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 7154	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 10/12/2023
NAME OF PROVIDER OR SUPPLIER SINGING ARROW AFH LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 12904 PIRU BLVD SE ALBUQUERQUE, NM 87123		
(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 035	Continued From page 27 PRN medications shall be reported to the PCP. D. Only a licensed nurse (RN or LPN) shall administer any medications or conduct any invasive procedures provided by the following routes: intravenous (IV), subcutaneous (SQ), intramuscular (IM), vaginal or rectal. Only a licensed nurse shall administer non-premixed nebulizer treatments. E. The facility shall have medication reference material that contains information relating to drug interactions and side effects on the premises. Staff that assist in the self-administration of medications shall know interactions or possible side effects that might occur. F. Medications prescribed for one resident shall not be used for another resident. G. Medication assistance record (MAR). For residents who are not independent and require assistance with self administration, the facility shall have a MAR that documents the details of the residents' medication, including PRN and over-the-counter medication that is assisted with self-administration by qualified staff or administered to the resident by licensed or certified staff. The information in the MAR shall include: (1) the resident's name; (2) any known allergies to medication that the resident has; (3) the name of the resident's PCP or the prescriber of the medication; (4) the diagnosis or reason for the medication; (5) the name of the medication, including the drug product brand name and the generic name; (6) notation if the medication is a schedule II-IV drug; (7) the dosage of the medication; (8) the strength of the medication; (9) the frequency or how often the medication is	A 035		

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 7154	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 10/12/2023
NAME OF PROVIDER OR SUPPLIER SINGING ARROW AFH LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 12904 PIRU BLVD SE ALBUQUERQUE, NM 87123		
(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 035	Continued From page 28 to be taken or given; (10) the route of delivery for the medication (mouth, eye, ear, other); (11) the method of delivery for the medication (pills, drops, IM injection, other); (12) the date that the medication was started or discontinued; (13) any change in the medication order; (14) pre-medication information (i.e., pulse, respiration, blood pressure, blood sugar) as required by the medication order; (15) the date and time that the medication is self-administered, administered with assistance or is administered; (16) the initials and signature of the person assisting with or administering the medication; (17) the desired results obtained from or problems encountered with the medication (pain relieved, allergic reaction, etc.); (18) any refused dose of medication; (19) any missed dose of medication; and (20) any medication error. H. No medication shall be stopped or started without specific orders from the primary care physician. I. If a resident refuses to take a prescribed medication, it shall be documented and the facility shall report it to the prescriber. J. A suspected adverse reaction to a medication shall be documented on the MAR and reported immediately to the PCP and the resident's surrogate decision maker. If applicable, emergency medical treatment shall be arranged. Documentation of the event shall be kept in the resident's record. K. Prescription medication, other than blister packs and unit dose containers, shall be kept in the original container with a pharmacy label that includes the following:	A 035		

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 7154	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 10/12/2023
NAME OF PROVIDER OR SUPPLIER SINGING ARROW AFH LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 12904 PIRU BLVD SE ALBUQUERQUE, NM 87123		
(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 035	Continued From page 29 (1) the resident's name; (2) the name of the medication; (3) the date that the prescription was issued; (4) the prescribed dosage and the instructions for administration of the medication; and (5) the name and title of the prescriber. L. Any medication that is removed from the pharmacy container or blister pack shall be given immediately and documented by the staff that assisted with the medication delivery. M. The facility shall report all medication errors to the physician, documentation of medication errors and the prescriber's response shall be kept in the resident's record. N. The facility shall develop and follow a written policy for unused, outdated, or recalled medications kept in the facility in accordance with 16.19.11.10 NMAC (AS AMENDED). [7.8.2.35 NMAC - Rp, 7.8.2.35 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.35 B Based on record review and interview, the facility failed to ensure that all staff that assist with self-administration of medications had successfully completed a state approved assistance with self-administration of medication training program. This deficient practice could potentially negatively affect all [REDACTED] residents identified of the census provided by the Administrator on [REDACTED]/23 to be at risk of harm if residents are receiving assistance with medications by staff who have not received proper training.	A 035		

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 7154	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/12/2023
NAME OF PROVIDER OR SUPPLIER SINGING ARROW AFH LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 12904 PIRU BLVD SE ALBUQUERQUE, NM 87123			
(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 035	Continued From page 30 The findings are: A. Record review of the Administrators training file did not contain any documentation of having completed a state approved assistance with self-administration of medication training program. B. On [REDACTED] /23 at 11:50 am, during an interview, the Administrator confirmed she had not completed a state approved assistance with self-administration of medication training program.	A 035			
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 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 A B Based on observation and interview, the facility	A 042	WHAT: MAINTENANCE OF GROUNDS The noted hazards have been removed from the area and have either been placed in the locked in the shed located in the backyard or removed from the property. WHEN: ONCE A WEEK MAINTANENCE WILL BE PERFORMED TO KEEP GROUNDS FREE AND CLEAR OF OBSTRUCTIONS HOW: ADMINISTRATOR WILL CLEAN AND CLEAR WALKWAYS AROUND FACILITY WHO: ADMINISTRATOR WILL PERFORM A WEEKLY WALK TRU AROUND PREMISES	[REDACTED] /2023	

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 7154	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 10/12/2023
NAME OF PROVIDER OR SUPPLIER SINGING ARROW AFH LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 12904 PIRU BLVD SE ALBUQUERQUE, NM 87123		
(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 042	Continued From page 31 failed to ensure that the facility storage area/grounds and floors were maintained in a safe, sanitary, and presentable condition. This deficient practice has the potential for all █ residents identified on the resident census provided by the Administrator █/23, to be at risk of being injured from safety and tripping/falling hazards. The finding are: A. On █1/23 at 1:37 pm, during observation of the exterior back yard, the following items created a safety/tripping hazard to residents were revealed: 1. The Westside gate area and walkway was overgrown with a tree and shrubs. 2. Three (3) bedside commodes stored next to the West pathway exit 3. Two (2) trashcans stored next to the West pathway exit 4. One (1) steel bedframe stored on the back patio 5. One (1) hand dolly stored on the back patio 6. One (1) living room chair stored on the back patio 7. One (1) wooden bedframe stored on the back patio 8. Twelve (12) outdoor patio chairs stored in the back yard 9. Two (2) patio storage containers stored in the backyard 10. One (1) wheelbarrow containing rocks stored in the backyard 11. One (1) wooden nightstand stored on the back patio 12. Two (2) bags of rugs and carpet items stored on the back patio 13. One (1) ladder stored next to the East	A 042		

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 7154	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 10/12/2023
NAME OF PROVIDER OR SUPPLIER SINGING ARROW AFH LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 12904 PIRU BLVD SE ALBUQUERQUE, NM 87123		
(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 042	Continued From page 32 pathway exit B. On [REDACTED]/23 at 1:50 pm, during an interview, the Administrator confirmed the following items were in the exterior back yard and created a safety/tripping hazard to residents: 1. The Westside gate area and walkway was overgrown with a tree and shrubs. 2. Three (3) bedside commodes 3. Two (2) trashcans 4. One (1) steel bedframe 5. One (1) hand dolly 6. One (1) living room chair 7. One (1) wooden bedframe 8. Twelve (12) outdoor patio chairs 9. Two (2) patio storage containers 10. One (1) wheelbarrow containing rocks 11. One (1) wooden nightstand 12. Two (2) bags of rugs and carpet items 13. One (1) ladder	A 042		
A 047	7 NMAC 8.2.47 Lighting and Lighting Fixtures LIGHTING AND LIGHTING FIXTURES: 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.	A 047	WHAT: LIGHTING AND LIGHTING ISSUES The lighted exit signs have been cprrected and npw are in wprking prder. WHEN: ELECTRIC COMPANY TO VISIT IN 3 DAYS THE FACILITY HOW: APPOINTMENT MADE TO LOCAL ELECTRIC COMPANY TO RESOLVE LIGHTING ISSUES WHO: ADMINISTRATOR CALLED THE ELECTRIC COMPANY	[REDACTED]/2023

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 7154	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 10/12/2023
NAME OF PROVIDER OR SUPPLIER SINGING ARROW AFH LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 12904 PIRU BLVD SE ALBUQUERQUE, NM 87123		
(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 047	Continued From page 33 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 E Based on observation and interview the facility failed to ensure that all the emergency lights in the facility were in working order. This deficient practice could likely result in the █ residents identified on the resident census provided by the Administrator on █/23, to be at risk of harm, injury, or death, if there is a power outage or other emergency requiring evacuation and the residents cannot see to safely exit the building. The findings are: A. On █/23 at 10:56 am, during observation and testing of the emergency light near rooms 1G and 2G the emergency light failed to light up when tested. B. On █/23 at 11:07 am, during an interview, the Administrator confirmed the emergency light near rooms █ and █ failed to light up when tested.	A 047		

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 7154	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 10/12/2023
NAME OF PROVIDER OR SUPPLIER SINGING ARROW AFH LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 12904 PIRU BLVD SE ALBUQUERQUE, NM 87123		
(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 050	7 NMAC 8.2.50 Exits EXITS: A. The facility shall have at least two (2) approved exits, that do not involve windows and which are remote from each other. B. Facilities with ten (10) or more residents shall have each exit clearly marked with lighted signs having letters at least six (6) inches high and at least three-quarters (3/4) of an inch wide. Exit signs shall be visible at all times. C. Facilities with three (3) or fewer residents shall have a flashlight that is immediately available for use in lieu of electrically interconnected emergency lighting. D. Exits shall be clear of obstructions at all times. E. Exits, exit paths, or means of egress shall not pass through hazardous areas, garages, storerooms, closets, utility rooms, laundry rooms, bedrooms, or spaces subject to locking. F. For facilities with four (4) or more residents, sliding doors are not acceptable as a required exit. EXCEPTION: Assisted living facilities with three (3) or fewer residents may have sliding doors as required exits. G. When the yard gate(s) is part of the exit access and is locked, the gate shall be connected to the fire protection system and release upon activation of the fire/smoke system or shall have the ability to be unlocked at the gate site. [7.8.2.50 NMAC - Rp, 7.8.2.51 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.50 G Based on observation, and interview the facility failed to ensure that the locked backyard gate on	A 050	WHAT: EXITS SIGNS PROPERLY PLACED AND IN OPERATION The side gate dpes have a lpck placed and checked fpr wrking prdr. The key fpr the back gate will be readily utilized in case pf an emergency with the key being placed alpng with the key the backdppr WHEN: ELECTRIC COMPANY TO VISIT IN 3 BUSINESS DAYS FOR MAINTENANCE OF FACILITY LIGHTING IN GENERAL HOW: APPOINTMENT SCHEDULED WITH LOCAL COMPANY TO MAINTAIN WORKING EXIT LIGHTING WHO: ADMINISTRATOR WILL TEST MONTHLY OF PROPER OPERATION OF LIGHTING	██████/2023

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 7154	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 10/12/2023
NAME OF PROVIDER OR SUPPLIER SINGING ARROW AFH LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 12904 PIRU BLVD SE ALBUQUERQUE, NM 87123		
(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 050	Continued From page 35 the Northeast side of the facility which is part of the back yard exit path and egress route (this path would be used to move residents to the front of the building if they were to exit the facility through the back door during an emergency) was able to be readily unlocked at the gate site. This deficient practice could likely result in all [REDACTED] current residents listed on the census provided by Administrator on [REDACTED]/23, to be at risk of injury or harm if they are unable to safely evacuate the building in case of a fire or other emergency that requires evacuation because the gate cannot be readily opened. The finding are: A. On [REDACTED]/23 at 1:39 pm, during observation of the back yard exit path/egress pathway on the Northeast side there was a four (4) foot tall tan wrought iron gate that was locked with a steel chain and keyed padlock. B. On [REDACTED]/2023 at 1:50 pm during an interview, the Administrator confirmed the Northeast Gate was kept locked at all times and that the key was not available to readily unlock at the gate site.	A 050		
A 063	7 NMAC 8.2.63 Fire Extinguishers FIRE EXTINGUISHERS: Fire extinguisher(s) must be located in the facility, as approved by the state fire marshal or the fire prevention authority with jurisdiction. A. Facilities must as a minimum have two (2) 2A10BC fire extinguishers: (1) one (1) extinguisher located in the kitchen or food preparation area; (2) one (1) extinguisher centrally located in the facility; (3) all fire extinguishers shall be inspected yearly and recharged as needed; all fire extinguishers	A 063	WHAT: FIRE EXTINGUISHERS INSPECTIONS/MAINTENANCE WHEN: LOCAL FIRE SAFETY COMPANY VISITING FACILITY WITHIN 3 BUSINESS DAYS HOW: ADMINISTRATOR CONTACTED LOCAL FIRE SAFETY COMPANY TO RESOLVE ISSUES WHO: ADMINISTRATOR MADE APPOINTMENT WITH LOCAL FIRE SAFETY COMPANY There are two fire extinguishers located with one in the kitchen and the other in the hallway. Each serviced on October of 2023, giving a new servicing date of October of 2024.	[REDACTED]/2023

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 7154	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 10/12/2023
NAME OF PROVIDER OR SUPPLIER SINGING ARROW AFH LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 12904 PIRU BLVD SE ALBUQUERQUE, NM 87123		
(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 063	Continued From page 36 must be tagged noting the date of the inspection; (4) the maximum distance between fire extinguishers shall be fifty (50) feet. B. Fire extinguishers, alarm systems, automatic detection equipment and other fire fighting equipment shall be properly maintained and inspected as recommended by the manufacturer, state fire marshal, or the local fire authority. [7.8.2.63 NMAC - Rp, 7.8.2.62 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.63 A (3) B Reference NAPA 10, Standard for Portable Fire Extinguishers, 1998 Edition: 4-3 Inspection. 4-3.1* Frequency. Fire extinguishers shall be inspected when initially placed in service and thereafter at approximately 30 day intervals. Fire extinguishers shall be inspected at more frequent intervals when circumstances require. Based on observation and interview, the facility failed to ensure that fire extinguishers were being inspected yearly and monthly as recommended by the manufacturer. This deficient practice could likely result in the [REDACTED] residents identified on the census provided by the Administrator on [REDACTED]/23, staff members, and other building occupants to be at risk of harm, injury, or death if a fire were to occur and the fire extinguishers did not work. The findings are: A. On [REDACTED]/23 at 1:34 pm, during observation of	A 063		

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 7154	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 10/12/2023
NAME OF PROVIDER OR SUPPLIER SINGING ARROW AFH LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 12904 PIRU BLVD SE ALBUQUERQUE, NM 87123		
(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 063	Continued From page 37 the facility's fire extinguishers, it was found that 2 of 2 fire extinguishers had expired after the last Annual Inspection completed in December 2021 and were not initialed as being inspected monthly as recommended by the manufacturer. B. On [REDACTED] /23 at 1:45 pm, during an interview, the Administrator confirmed the fire extinguishers in the facility had expired after the last Annual Inspection completed in December 2021 and were not initialed as being inspected monthly as recommended by the manufacturer.	A 063		
A 064	7 NMAC 8.2.64 Fire Safety Equivalency System Rating FIRE SAFETY EQUIVALENCY SYSTEM RATING: In facilities without a sprinkler system; the fire safety equivalency system shall be conducted at least annually. The facility shall maintain an evacuation rating score of prompt when a fire safety equivalency system is required. [7.8.2.64 NMAC - Rp, 7.8.2.19 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.64 Based on record review and interview, the facility failed to ensure that the Fire Safety Equivalency System Rating (FSER) score forms were completed at least annually and available for review. This deficient practice could likely result in all [REDACTED] residents identified on the census, provided by the Administrator on [REDACTED] /23, to be at risk of harm, injury, or death if there are not enough staff on duty to safely	A 064	WHAT: FIRE SAFETY EQUIPMENT SYSTEM INSPECTION Fire safety sheets will be COMPLETED and kept in residents file . WHEN: LOCAL FIRE SAFETY COMPANY VISITING FACILITY WITHIN 3 BUSINESS DAYS HOW: ADMINISTRATOR CONTACTED LOCAL FIRE SAFETY COMPANY TO RESOLVE ISSUES WHO: ADMINISTRATOR MADE APPOINTMENT WITH LOCAL FIRE SAFETY COMPANY	[REDACTED] /2023

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 7154	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 10/12/2023
NAME OF PROVIDER OR SUPPLIER SINGING ARROW AFH LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 12904 PIRU BLVD SE ALBUQUERQUE, NM 87123		
(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 064	Continued From page 38 evacuate the residents if a fire were to occur. The findings are: A. Record requested dated [REDACTED]/23 revealed that there was no documentation of any FSES forms available to review. B. On [REDACTED]/23 at 1:51 pm, during an interview, the Administrator confirmed that the facility had not completed the FSES forms and they were not available for review.	A 064			
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. C. If applicable, the local fire department may be requested to supervise and participate in fire drills. [7.8.2.65 NMAC - Rp, 7.8.2.65 NMAC, 01/15/2010]	A 065	WHAT: MONTHLY FIRE DRILLS WHEN: FIRE DRILLS ARE LOG IN MONTHLY AT DIFFERENT TIMES OF THE DAY HOW: ONE FIRE DRILL MONTHLY IN THE MORNING, ONE IN THE AFTERNOON AND ONE AT THE EVENING WHO: ADMINISTRATOR TO PARTICIPATE/SUPERVISE MONTHLY DRILLS	[REDACTED]/2023	

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 7154	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 10/12/2023
NAME OF PROVIDER OR SUPPLIER SINGING ARROW AFH LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 12904 PIRU BLVD SE ALBUQUERQUE, NM 87123		
(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 065	Continued From page 39 This REQUIREMENT is not met as evidenced by: 7.8.2.65 A Based on record review and interview, the facility failed to ensure that fire drills were conducted monthly. 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 a fire were to occur and the Direct Care Staff (DCS) do not know how to safely evacuate the residents from the building. The findings are: A. Record request on 1 [REDACTED]/23 at 9:30 am, for the facility's fire drill records from April 2023 through September 2023, revealed no documentation that any fire drills were conducted for the months of April 2023 through September 2023. B. On [REDACTED]/23 at 1:51 pm, during an interview, the Administrator confirmed that the facility had not conducted any fire drills for the months of April 2023 thru September 2023.	A 065		