

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 2298	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 07/23/2024
NAME OF PROVIDER OR SUPPLIER MORNINGSTAR MEMORY CARE AT NORTH RIDGE		STREET ADDRESS, CITY, STATE, ZIP CODE 8101 PALOMAS AVE NE ALBUQUERQUE, NM 87109		
(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	<p>Initial Comments</p> <p>The following deficiencies were cited during a Regulation Review Survey and Complaint survey completed on 07/23/24 for the state requirements of NMAC 8.370.14, Regulations for Assisted Living Facilities for Adults.</p> <p>Resident Census: 47</p> <p>Complaint Intake: NM [REDACTED] was investigated, with deficiencies cited.</p>	A 000		
A 033	<p>7 NMAC 8.2.33 Resident Rights</p> <p>RESIDENT RIGHTS: All licensed facilities shall understand, protect and respect the rights of all residents.</p> <p>A. Prior to admission to a facility, a resident and legal representative shall be given a written description of the legal rights of the resident, translated into another language, if necessary, to meet the resident's understanding.</p> <p>B. If the resident has no legal representative and is incapable of understanding his or her legal rights, a written copy of the resident's legal rights shall be provided to the most significant responsible party in the following order:</p> <p>(1) the resident's spouse; (2) significant other; (3) any of the resident's adult children; (4) the resident's parents; (5) any relative the resident has lived with for six or more months before admission; (6) a person who has been caring for, or paying benefits on behalf of the resident; (7) a placing agency; (8) resident advocate; or (9) the ombudsman.</p> <p>C. The resident rights shall be posted in a conspicuous public place in the facility and shall</p>	A 033		

Division of Health Improvement

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

Morgan O'Rourke

STATE FORM

6599

MQM511

TITLE

Executive Director

revised

(X6) DATE

11/11/2024

If continuation sheet 1 of 18

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 2298	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 07/23/2024
NAME OF PROVIDER OR SUPPLIER MORNINGSTAR MEMORY CARE AT NORTH RIDGE		STREET ADDRESS, CITY, STATE, ZIP CODE 8101 PALOMAS AVE NE ALBUQUERQUE, NM 87109		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 033	<p>Continued From page 1</p> <p>include the telephone numbers for the incident management hotline and for the state ombudsman program.</p> <p>D. To protect resident rights, the facility shall:</p> <ul style="list-style-type: none"> (1) treat all residents with courtesy, respect, dignity and compassion; (2) not discriminate in admission or services based on gender, sexual orientation, resident's age, race, religion, physical or mental disability, or nationality; (3) provide residents written information about all services provided by the facility and their costs and give advance written notice of any changes; (4) provide residents with a safe and sanitary living environment; (5) provide humane care for all residents; (6) provide the right to privacy, including privacy during medical examinations, consultations and treatment; (7) protect the confidentiality of the resident's medical record; (8) protect the right to personal privacy, including privacy in personal hygiene; privacy during visits with a spouse, family member or other visitor; and privacy in the resident's own room; (9) protect the right to communicate privately and freely with any person, including private telephone conversations and private correspondence; and the right to receive visits from family, friends, lawyers, ombudsmen and community organizations; (10) prohibit the use of any and all physical and chemical restraints; (11) ensure that residents: <ul style="list-style-type: none"> (a) are free from physical and emotional abuse neglect and misappropriation/or exploitation; (b) are free from financial abuse and misappropriation by facility staff or management; (c) are free to participate in religious, social, 	A 033		

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 2298	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 07/23/2024
NAME OF PROVIDER OR SUPPLIER MORNINGSTAR MEMORY CARE AT NORTH RIDGE		STREET ADDRESS, CITY, STATE, ZIP CODE 8101 PALOMAS AVE NE ALBUQUERQUE, NM 87109		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 033	<p>Continued From page 2</p> <p>community and other activities and freely associate with persons in and out of the facility;</p> <p>(d) are free to leave the facility and return without unreasonable restriction;</p> <p>(e) are given a fifteen (15) calendar day, written notice before room transfers or discharge from the facility unless there is immediate danger to self or others in the facility;</p> <p>(f) have an environment that fosters social interaction and avoids social isolation;</p> <p>(g) or their surrogate decision makers, are informed of and consent to the services provided by the facility;</p> <p>(h) have the right to voice grievances to the facility staff, public officials, the ombudsmen, any state agency, or any other person, without fear of reprisal or retaliation;</p> <p>(i) have the right to have their complaints addressed within fourteen (14) calendar days or sooner;</p> <p>(j) have the right to participate in the development of their care plan/ISP;</p> <p>(k) have the right to choose a doctor, pharmacist and other health care provider(s);</p> <p>(l) have the right to participate in medical treatment decisions and formulate advance directives such as living wills and powers of attorney;</p> <p>(m) have the right to keep and use personal possessions without loss or damage;</p> <p>(n) have the right to manage and control their personal finances;</p> <p>(o) have the right to freely organize and participate in a resident association that may recommend changes in the facility's policies, services and management;</p> <p>(p) shall not be required to work for the facility; and</p> <p>(q) are protected from unjustified room transfers</p>	A 033		

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 2298	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 07/23/2024
NAME OF PROVIDER OR SUPPLIER MORNINGSTAR MEMORY CARE AT NORTH RIDGE		STREET ADDRESS, CITY, STATE, ZIP CODE 8101 PALOMAS AVE NE ALBUQUERQUE, NM 87109		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 033	<p>Continued From page 3</p> <p>or discharge.</p> <p>E. The resident's rights shall not be restricted unless this restriction is for the health and safety of the resident, agreed to by the resident or the resident's surrogate decision maker and outlined in the resident's individual service plan. [7.8.2.33 NMAC - Rp, 7.8.2.34 NMAC, 01/15/2010]</p> <p>This REQUIREMENT is not met as evidenced by: 8.370.14.33 D (1) (4) (5) (10) (11) (a)</p> <p>Based on record review and interview, the facility failed to ensure for 1 (R # 1) of 3 (R #s 1 - 3) residents who were reviewed that the residents were:</p> <ul style="list-style-type: none"> 1. Treated with courtesy, respect, dignity, and compassion. 2. Provided with a safe environment. 3. Provided with humane care. 4. Free from any and all physical and chemical restraints 5. Free from physical and emotional abuse. <p>These deficient practices could likely result in the residents to be at risk of harm or injury if the residents were not:</p> <ul style="list-style-type: none"> 1. Treated with courtesy, respect, dignity, and compassion. 2. Provided with a safe environment. 3. Provided with humane care. 4. Free from any and all physical and chemical restraints 5. Free from physical or emotional abuse. <p>The findings are:</p>	A 033	<p>A 033 DCS #3 reported the witnessed incident (A 033) to her direct supervisor, the Reflection Coordinator (RC), on 06/05/2024. The RC immediately reported the incident to the Executive Director (ED). The ED and RC investigated the report, which led to termination of the alleged DCS #1. ED self-reported the incident to DOH.</p> <p>ED will review 2 trainings with all employees (1) Preventing, Recognizing, and Reporting Abuse, and (2) Understanding Abuse and Neglect on 10/17/2024 during the monthly staff meeting. Any employees that are unable to attend the staff meeting will be assigned to complete the two aforementioned trainings online via a training software, to be due by 10/19/2024. Abuse and neglect is a training that all Morningstar employees are required to review upon hire and annually.</p> <p>In addition, all Department Heads will attend an online meeting on 10/21/2024 with Complaint Team Lead from HCA to review the incident reporting processes and maintain compliance with reporting standards, which will be monitored by ED and WD.</p>	10/17/24 10/19/24 10/21/24

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 2298	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 07/23/2024
NAME OF PROVIDER OR SUPPLIER MORNINGSTAR MEMORY CARE AT NORTH RIDGE		STREET ADDRESS, CITY, STATE, ZIP CODE 8101 PALOMAS AVE NE ALBUQUERQUE, NM 87109		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 033	<p>Continued From page 4</p> <p>A. Record review of Complaint Intake NM [REDACTED] received on 06/14/24 revealed that on 06/02/24 around 8:30 - 9:30 pm, Direct Care Staff (DCS) #3 witnessed DCS #1 putting R #1 to bed. DCS #1 wrapped the resident in a blanket in such a way that the resident could not free themselves and also tied a shirt around the residents legs restraining [REDACTED]</p> <p>B. Record review of R #1's Individual Service Plan (ISP) dated 05/29/24 revealed a diagnosis of [REDACTED]</p> <p>C. Record review of the facility's Incident Report (IR) dated 06/05/24 revealed:</p> <ol style="list-style-type: none"> 1. On 06/02/24, between 8:30-9:00 pm, DCS #3 was called to R #1's room. DCS #3 observed that DCS #1 had physically restrained R #1 by lightly wrapping R #1 in a blanket and was unable to free [REDACTED]. DCS #1 also tied R #1's ankles with a long-sleeve shirt. 2. DCS #1 left R #1's room, DCS #3 freed R #1 from the blanket and shirt. 3. DCS #3 did not report incident to the Reflections Coordinator (supervises and schedules DCS staff) until 06/05/24 due to fear of retaliation by DCS #1. 4. The Reflections Coordinator immediately verbally reported incident to the Executive Director. 5. After the Executive Director received the Internal Incident report (dated 06/05/24) from DCS #3. DCS #1 was terminated, effective 06/06/24. <p>D. On 07/17/24 at 2:19 pm, during an Interview with DCS #3 she described her observation on 06/02/24 when DCS #1 called DCS #3 into R #1's</p>	A 033		

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 2298	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 07/23/2024
NAME OF PROVIDER OR SUPPLIER MORNINGSTAR MEMORY CARE AT NORTH RIDGE		STREET ADDRESS, CITY, STATE, ZIP CODE 8101 PALOMAS AVE NE ALBUQUERQUE, NM 87109		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 033	<p>Continued From page 5</p> <p>room to witness R#1 laying down in [REDACTED] bed with [REDACTED] upper body wrapped tightly in a blanket in which R #1 was unable to free [REDACTED] DCS #3 also observed R #1's legs restricted by a long-sleeved shirt tied in a knot in a manner which R #1 was unable to free [REDACTED] ankles. The blanket and the long-sleeve shirt were used by DCS #1 to restrict R #1's physical movement.</p> <p>E. On 07/22/24 at 4:25 pm, during an interview with the Executive Director (ED), she confirmed that DCS #1 physically restrained R #1 on 06/02/24.</p>	A 033		
A 035	<p>7 NMAC 8.2.35 Medication</p> <p>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.</p> <p>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.</p> <p>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</p>	A 035		

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 2298	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 07/23/2024
NAME OF PROVIDER OR SUPPLIER MORNINGSTAR MEMORY CARE AT NORTH RIDGE		STREET ADDRESS, CITY, STATE, ZIP CODE 8101 PALOMAS AVE NE ALBUQUERQUE, NM 87109		
(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	<p>Continued From page 6</p> <p>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.</p> <p>C. PRN (pro re nada) medication.</p> <p>(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.</p> <p>(2) The utilization of PRN medications shall be reviewed routinely. Frequent or escalating use of PRN medications shall be reported to the PCP.</p> <p>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.</p> <p>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.</p> <p>F. Medications prescribed for one resident shall not be used for another resident.</p> <p>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</p>	A 035		

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 2298	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 07/23/2024
NAME OF PROVIDER OR SUPPLIER MORNINGSTAR MEMORY CARE AT NORTH RIDGE		STREET ADDRESS, CITY, STATE, ZIP CODE 8101 PALOMAS AVE NE ALBUQUERQUE, NM 87109		
(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	<p>Continued From page 7</p> <p>include:</p> <p>(1) the resident's name;</p> <p>(2) any known allergies to medication that the resident has;</p> <p>(3) the name of the resident's PCP or the prescriber of the medication;</p> <p>(4) the diagnosis or reason for the medication;</p> <p>(5) the name of the medication, including the drug product brand name and the generic name;</p> <p>(6) notation if the medication is a schedule II-IV drug;</p> <p>(7) the dosage of the medication;</p> <p>(8) the strength of the medication;</p> <p>(9) the frequency or how often the medication is to be taken or given;</p> <p>(10) the route of delivery for the medication (mouth, eye, ear, other);</p> <p>(11) the method of delivery for the medication (pills, drops, IM injection, other);</p> <p>(12) the date that the medication was started or discontinued;</p> <p>(13) any change in the medication order;</p> <p>(14) pre-medication information (i.e., pulse, respiration, blood pressure, blood sugar) as required by the medication order;</p> <p>(15) the date and time that the medication is self-administered, administered with assistance or is administered;</p> <p>(16) the initials and signature of the person assisting with or administering the medication;</p> <p>(17) the desired results obtained from or problems encountered with the medication (pain relieved, allergic reaction, etc.);</p> <p>(18) any refused dose of medication;</p> <p>(19) any missed dose of medication; and</p> <p>(20) any medication error.</p> <p>H. No medication shall be stopped or started without specific orders from the primary care physician.</p>	A 035		

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 2298	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 07/23/2024
NAME OF PROVIDER OR SUPPLIER MORNINGSTAR MEMORY CARE AT NORTH RIDGE		STREET ADDRESS, CITY, STATE, ZIP CODE 8101 PALOMAS AVE NE ALBUQUERQUE, NM 87109		
(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	<p>Continued From page 8</p> <p>I. If a resident refuses to take a prescribed medication, it shall be documented and the facility shall report it to the prescriber.</p> <p>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.</p> <p>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:</p> <p>(1) the resident's name;</p> <p>(2) the name of the medication;</p> <p>(3) the date that the prescription was issued;</p> <p>(4) the prescribed dosage and the instructions for administration of the medication; and</p> <p>(5) the name and title of the prescriber.</p> <p>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.</p> <p>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.</p> <p>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).</p> <p>[7.8.2.35 NMAC - Rp, 7.8.2.35 NMAC, 01/15/2010]</p> <p>This REQUIREMENT is not met as evidenced by:</p>	A 035		

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 2298	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 07/23/2024
NAME OF PROVIDER OR SUPPLIER MORNINGSTAR MEMORY CARE AT NORTH RIDGE		STREET ADDRESS, CITY, STATE, ZIP CODE 8101 PALOMAS AVE NE ALBUQUERQUE, NM 87109		
(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	<p>Continued From page 9</p> <p>8.370.14.35 G (7) (9) (20)</p> <p>Based on record review and interview, the facility failed to ensure for 2 (R #'s 2 and 4) of 4 (R #'s 1-4) residents reviewed for medication errors that the medications listed on the Medication Administration Record (MAR) included the correct dosage and/or frequency of the medication administered.</p> <p>These deficient practices could likely result in the residents being at risk of harm/injury due to medication errors if the medications listed on the MARs do not include the correct dosage of the medication and/or how often the medication should be administered.</p> <p>Findings for R #2:</p> <p>A. Record review of R #2's physician order, dated 7/12/2024, revealed [REDACTED]</p> <p>[REDACTED]</p> <p>B. Record review of R #2's MAR for 7/13/2024 and 07/14/24 revealed [REDACTED]</p> <p>[REDACTED]</p> <p>C. Record review of R #2's physician order, dated 6/19/2024, revealed [REDACTED]</p> <p>[REDACTED]</p> <p>[REDACTED] were given together on 7/10/2024 at 2:25 pm with the</p>	A 035	<p>A 035</p> <p>Upon internal discovery of medication errors via ED and WN, ED placed WD on a final performance counseling (write-up) and performance improvement plan to maintain accuracy and compliance with medication orders. During the HCA review, additional medication errors were discovered which led to the ED placing the WD on immediate administrative leave for further investigation. During the internal investigation, the WD chose not to return to Morningstar.</p> <p>Morningstar's Pharmacy consultant performs a quarterly MAR-to-med cart audit, and Morningstar's new WD will perform on-going monthly MAR-to-med cart audits to monitor compliance. New medication orders are reviewed and approved weekly by WD.</p>	07/22/24

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 2298	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 07/23/2024
NAME OF PROVIDER OR SUPPLIER MORNINGSTAR MEMORY CARE AT NORTH RIDGE		STREET ADDRESS, CITY, STATE, ZIP CODE 8101 PALOMAS AVE NE ALBUQUERQUE, NM 87109		
(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	<p>Continued From page 10</p> <p>administration of both medications listed as 'effective' in the MAR outcome column. Both medications [REDACTED] were repeated at 5:05 pm with the administration of both medications listed as 'not effective', in the MAR outcome column. The second administration dose of [REDACTED] was given 2 hours and 40 minutes after the first dose.</p> <p>Documentation in the MAR, shows that the Wellness Director advised the Medication Technician both times to administer the [REDACTED] and [REDACTED] at 2:25 pm and 5:05 pm.</p> <p>D. Record review and interview with the Wellness Director of R #2's MAR dated 7/10/24 confirmed the two medication entries of [REDACTED] and [REDACTED]. Wellness Director confirmed that she approved the medication administration at 2:25 pm but that she leaves work at 5:00pm. MAR purpose for 5:05 pm administration of Morphine shows documentation that Wellness Director advised to administer.</p> <p>Findings for R #4:</p> <p>D. Record review of R #4's physician order dated 7/11/24 revealed [REDACTED]</p> <p>[REDACTED] REPLACES all other [REDACTED] orders.</p> <p>E. Record review of R #4's MAR for 7/11/2024 revealed that [REDACTED]</p> <p>[REDACTED] added to the MAR. The MAR did not show that the other [REDACTED] orders were discontinued per MD order. This resulted in duplicate orders in the MAR, resulting in the resident receiving more [REDACTED] than the physician order indicated.</p>	A 035		

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 2298	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 07/23/2024
NAME OF PROVIDER OR SUPPLIER MORNINGSTAR MEMORY CARE AT NORTH RIDGE		STREET ADDRESS, CITY, STATE, ZIP CODE 8101 PALOMAS AVE NE ALBUQUERQUE, NM 87109		
(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	<p>Continued From page 11</p> <p>F. On 07/17/24 at 4:00 pm, during an interview, the Administrator confirmed that R #2's MAR's dated 07/10/24, 07/13/24 and 07/14/24 and R #4's MAR dated 07/11/24 contained medication errors regarding the dosage and the frequency or how often the medication is to be taken or given.</p> <p>G. Record review of R #4's MAR revealed that the physician for R #4 was notified on 7/18/24 of the medication error of receiving more [REDACTED] than the physician order indicated.</p> <p>H. Record review of R #2's MAR revealed that the physician for R #2 was notified, on 7/18/24, of the medication error of receiving more [REDACTED] and [REDACTED] than the physician order indicated for frequency and R #2's medication error of receiving less [REDACTED] than the physician originally ordered.</p>	A 035		
A 036	<p>8 NMAC 370.14.36 Nutrition</p> <p>The facility shall provide planned and nutritionally balanced meals from the basic food groups in accordance with the "recommended daily dietary allowance" of the American dietetic association, the food and nutrition board of the national research council, or the national academy of sciences. Meals shall meet the nutritional needs of the residents in accordance with the "2005 USDA dietary guidelines for Americans." Vending machines shall not be considered a source of snacks.</p> <p>A. Dietary services policies and procedures: The facility will develop and implement written policies and procedures that are maintained on the premises and that govern the following requirements.</p> <p>(1) Meal service: The facility shall:</p>	A 036		

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 2298	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 07/23/2024
NAME OF PROVIDER OR SUPPLIER MORNINGSTAR MEMORY CARE AT NORTH RIDGE		STREET ADDRESS, CITY, STATE, ZIP CODE 8101 PALOMAS AVE NE ALBUQUERQUE, NM 87109		
(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 036	<p>Continued From page 12</p> <p>(a) serve at least three meals or their equivalent each day at regular times with no more than 16 hours between the evening meal and morning meal with snacks freely available;</p> <p>(b) provide snacks of nourishing quality and post on the daily menu;</p> <p>(c) develop menus enjoyed by the residents and served at normal intervals appropriate to the residents' preferences;</p> <p>(d) post the weekly menu, including snacks where residents and families are able to view it; posted menus shall be followed and any substitution shall be of equivalent nutritional value and recorded on the posted menu; identical menus shall not be used within a one week cycle;</p> <p>(e) have special menus or meal items following guidelines from the resident's physician for residents who have medically prescribed special diets;</p> <p>(f) serve all residents in a dining room except for residents with a temporary illness, or with documented specific personal preference to have meals in their room;</p> <p>(g) allow sufficient time for meals to enable residents to eat at a leisurely pace and to socialize; and</p> <p>(h) contact the resident's PCP within 48 hours if a resident consistently refuses to eat.</p> <p>(2) Staff in-service training: The facility shall provide an in-service training program for staff that are involved in food preparation at orientation and at least annually and that includes:</p> <p>(a) instruction in proper food storage;</p> <p>(b) preparation and serving food;</p> <p>(c) safety in food handling;</p> <p>(d) appropriate personal hygiene; and</p> <p>(e) infectious and communicable disease control.</p> <p>B. Dietary records: The facility shall maintain the</p>	A 036		

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 2298	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 07/23/2024
NAME OF PROVIDER OR SUPPLIER MORNINGSTAR MEMORY CARE AT NORTH RIDGE		STREET ADDRESS, CITY, STATE, ZIP CODE 8101 PALOMAS AVE NE ALBUQUERQUE, NM 87109		
(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 036	<p>Continued From page 13</p> <p>following documentation onsite:</p> <p>(1) a systematic record of all menus and revisions, including snacks, for a minimum of thirty (30) calendar days;</p> <p>(2) a systematic record of therapeutic diets as prescribed by a PCP;</p> <p>(3) a copy of the most recent licensing inspection and for facilities with 10 or more residents, a copy of the New Mexico environment department inspection with notations made by the facility of action taken to comply with recommendations or citations; and</p> <p>(4) a daily log of the recorded temperatures for all facility refrigerators, freezers and steam tables maintained and available for inspection for 30 calendar days.</p> <p>C. Clean and sanitary conditions: All practices shall be in accordance with the standards of the state environment department, pursuant to 7.6.2 NMAC.</p> <p>(1) Kitchen sanitation:</p> <p>(a) Equipment and work areas shall be clean and in good repair. Surfaces with which food or beverages come into contact shall be of smooth, impervious material free of open seams, not readily corrodible and easily accessible for cleaning.</p> <p>(b) Utensils shall be stored in a clean, dry place protected from contamination.</p> <p>(c) The walls, ceiling and floors of all rooms that food or drink is stored, prepared or served shall be kept clean and in good repair.</p> <p>(2) Washing and sanitizing kitchenware:</p> <p>(a) All reusable tableware and kitchenware shall be cleaned in accordance with procedures that include separate steps for prewashing, washing, rinsing and sanitizing.</p> <p>(b) Proper dishwashing procedures and</p>	A 036		

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 2298	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 07/23/2024
NAME OF PROVIDER OR SUPPLIER MORNINGSTAR MEMORY CARE AT NORTH RIDGE		STREET ADDRESS, CITY, STATE, ZIP CODE 8101 PALOMAS AVE NE ALBUQUERQUE, NM 87109		
(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 036	<p>Continued From page 14</p> <p>techniques shall be utilized and understood by the dishwashing staff.</p> <p>(c) Periodic monitoring of the operation of the detergent dispenser, washing, rinsing and sanitizing temperatures shall be performed and documented.</p> <p>(d) When a dishwashing machine is utilized, the cleanliness of the machine, its jets and its thermostatic controls shall be monitored and documented by the facility. A monthly log of the recorded temperature of the dishwasher shall be maintained in the facility and available for inspection.</p> <p>(3) Sinks for hand washing shall include hot and cold running water, hand-washing soap and disposable towels.</p> <p>(4) All garbage and kitchen refuse that is not disposed of through a garbage disposal unit shall be kept in watertight containers with close-fitting covers and disposed of daily in a safe and sanitary manner.</p> <p>(5) Cooks and food handlers shall wear clean outer garments and hair nets or caps and shall keep their hands clean at all times when engaged in handling food, drink, utensils or equipment in accordance with the local health authority. Disposable gloves shall be used in accordance with the local health authority.</p> <p>D. Food management: The facility shall store, prepare, distribute and serve food under sanitary conditions and in accordance with the regulations governing food establishments of local health authority having jurisdiction.</p> <p>(1) The facility shall ensure that a minimum of a three calendar day supply of perishables and a five calendar day supply of non-perishables or canned foods is available for the residents.</p> <p>(2) The facility refrigerator and freezer shall have an accurate thermometer which reads within or</p>	A 036		

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 2298	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 07/23/2024
NAME OF PROVIDER OR SUPPLIER MORNINGSTAR MEMORY CARE AT NORTH RIDGE		STREET ADDRESS, CITY, STATE, ZIP CODE 8101 PALOMAS AVE NE ALBUQUERQUE, NM 87109		
(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 036	<p>Continued From page 15</p> <p>not more than plus or minus three degrees fahrenheit of the required temperature, located in the warmest section of the refrigerator and freezer and shall be accessible and easily read.</p> <p>(a) The temperature of the refrigerator shall be 35 - 41 degrees fahrenheit.</p> <p>(b) Freezer temperatures shall be maintained at zero degrees fahrenheit or below.</p> <p>(3) Refrigerators and freezers shall be kept clean and sanitary at all times. Food stored in refrigerators and freezers shall be covered, dated and labeled. Unused leftover food shall be discarded after three calendar days.</p> <p>(4) Steam tables, hot food tables, slow cookers, crock pots and other hot food holding devices shall not be used in heating or reheating food. Hot food temperatures shall be checked periodically to insure that a minimum of 140 degrees fahrenheit is maintained.</p> <p>(5) Medication, biological specimens, poisons, detergents and cleaning supplies shall not be kept in the same storage areas used for storage of foods. Medications shall not be stored in the refrigerator with food; an alternate refrigerator for medication shall be used.</p> <p>(6) Canned or preserved foods shall be procured from sources that process the food under regulated quality and sanitation controls. This does not preclude the use of local fresh produce. The facility shall not use home-canned foods.</p> <p>(7) Dry or staple food items shall be stored at least six inches off the floor in a ventilated room that is not subject to sewage, waste water back-flow or contamination by condensation, leakage, rodents or vermin.</p> <p>(8) The facility shall ensure the following:</p> <p>(a) all perishable food is refrigerated and the temperature is maintained no higher than 41 degrees fahrenheit;</p>	A 036		

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 2298	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 07/23/2024
NAME OF PROVIDER OR SUPPLIER MORNINGSTAR MEMORY CARE AT NORTH RIDGE		STREET ADDRESS, CITY, STATE, ZIP CODE 8101 PALOMAS AVE NE ALBUQUERQUE, NM 87109		
(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 036	<p>Continued From page 16</p> <p>(b) the temperature for all hot foods is maintained at 140 degrees fahrenheit; and</p> <p>(c) all displayed or transported food is protected from environmental contamination and maintained at proper temperatures in clean containers, cabinets or serving carts.</p> <p>E. Milk:</p> <p>(1) Raw milk shall not be used.</p> <p>(2) Condensed, evaporated, or dried milk products that are nationally recognized may be employed as "additives" in cooked food preparation but shall not be substituted or served to residents in place of milk.</p> <p>F. Collateral requirements: Compliance with this rule does not relieve a facility from the responsibility of meeting more stringent municipal regulations, ordinances or other requirements of state or federal laws governing food service establishments. Local health authority having jurisdiction means municipal, county, state or federal agency(s) that have laws and regulations governing food establishments, liquid waste disposal, treatment facilities and private wells. [8.370.14.36 NMAC - N, 7/1/2024]</p> <p>This REQUIREMENT is not met as evidenced by: 8.370.14.36 C (5) Based on observation and interviews, the facility failed to ensure cooks and food handlers wore hair nets or caps at all times when engaged in handling food, drink, utensils and equipment in accordance with the local health authority.</p> <p>This deficient practice could likely result in the 47 (R #s 1-47) residents identified on the census provided by the Administrator on 07/15/24, to be at risk of harm or contracting foodborne illnesses if food was not protected from biological hazards (harmful microorganisms or substances of</p>	A 036	<p>A 036</p> <p>The Morningstar culinary team failed to wear hair nets or caps at all times when engaged in handling food, drink, utensils and equipment.</p> <p>Morningstar's Executive Chef (EC) ordered hairnets on 07/16/2024, which were delivered on 07/17/2024 and implemented for use effective immediately.</p> <p>The Executive Chef will do monthly audits to monitor the supply and compliance of the use of hair nets or caps.</p>	07/17/24

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 2298	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 07/23/2024
NAME OF PROVIDER OR SUPPLIER MORNINGSTAR MEMORY CARE AT NORTH RIDGE		STREET ADDRESS, CITY, STATE, ZIP CODE 8101 PALOMAS AVE NE ALBUQUERQUE, NM 87109		
(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 036	<p>Continued From page 17</p> <p>biological origin that can cause foodborne illnesses when/if consumed) if kitchen staff are not wearing proper protective garments such as hair nets and caps.</p> <p>The findings are:</p> <p>A. On 07/16/24 at 11:46 am, during an observation of lunch, Cook #1 and #2 prepared and served lunch to the residents without wearing a hairnet or cap.</p> <p>B. On 07/16/24 at 11:46 am, during an interview with the executive chef, he confirmed that hairnets were being ordered, but no hairnets were available at the time.</p> <p>C. On 07/16/24 at 12:49 pm, during an interview with Cook #2, she stated, "We (kitchen staff) have not been wearing hairnets for five (5) years."</p>	A 036		