Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	4123	A. BUILDING: _____ B. WING _____	C 05/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONTECITO SANTA FE MEMORY CARE COMMUNITY	450 RODEO ROAD SANTA FE, NM 87505

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 000	Initial Comments The following deficiencies were cited during a Complaint survey completed on 05/08/24 for the state requirements of NMAC 7.8.2, Regulations for Assisted Living Facilities for Adults. Census: 38 Complaint Intake NM [redacted] was investigated, with deficiencies cited. Complaint Intake NM [redacted] was investigated, with deficiencies cited. Complaint Intake NM [redacted] was investigated, with no deficiencies cited. Complaint Intake NM [redacted] was investigated, with no deficiencies cited. Complaint Intake NM [redacted] was investigated, with no deficiencies cited.	A 000		
A 017	7 NMAC 8.2.17 Staff Training STAFF TRAINING: A. Training and orientation for each new employee and volunteer that provides direct care shall include a minimum of sixteen (16) hours of supervised training prior to providing unsupervised care for residents. B. Documentation of orientation and subsequent trainings shall be kept in the personnel file at the facility. C. Training shall be provided at orientation and at least twelve (12) hours annually, the orientation, training and proof of competency shall include: (1) fire safety and evacuation training; (2) first aid; (3) safe food handling practices (for persons involved in food preparation), to include: (a) instructions in proper storage; (b) preparation and serving of food; (c) safety in food handling;	A 017		

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A 017	Continued From page 1 (d) appropriate personal hygiene; and (e) infectious and communicable disease control; (4) confidentiality of records and resident information; (5) infection control; (6) resident rights; (7) reporting requirements for abuse, neglect or exploitation in accordance with 7.1.13 NMAC; (8) smoking policy for staff, residents and visitors; (9) methods to provide quality resident care; (10) emergency procedures; (11) medication assistance, including the certificate of training for staff that assist with medication delivery; and (12) the proper way to implement a resident ISP for staff that assist with ISPs. D. If a facility provides transportation to residents, employees of the facility who drive vehicles and transport residents shall have training in transportation safety for the elderly and disabled, including safe vehicle operation. [7.8.2.17 NMAC - Rp, 7.8.2.17 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.17 A B Based on record review and interview, the facility failed to ensure that the Direct Care Staff (DCS) completed and documented sixteen (16) hours of supervised training prior to providing unsupervised care for the residents required by regulation. This deficient practice could likely result in the 38 (R #s 1-38) residents listed on the resident census provided by the Administrator on 04/29/24, to be at risk of harm if they are	A 017	**7 NMAC 8.2.17** **Staff Training** **STAFF TRAINING:** Training and orientation for each new employee and volunteer that provides direct care shall include a minimum of sixteen (16) hours of supervised training prior to providing unsupervised care for residents. Documentation of orientation and subsequent training shall be kept in the personnel file at the facility. (Employee records maintenance) Employee personnel records and documentation of Orientation and subsequent trainings shall be maintained on-site by the Program Director to ensure ongoing compliance. The Program Director will be responsible for reviewing and updating the employee orientation forms during the orientation and training process within the first two weeks after date of hire.	8/30/24

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A 017	Continued From page 2 receiving care and services by DCS who have not completed the required trainings. The findings are: A. On 04/29/24 at 10:52 am, during an interview, DCS #5 stated that she "shadowed" another DCS for about fifteen (15) minutes before being left to work unsupervised with residents. B. Record review of DCS #5's (hire date 04/28/24) training file revealed the record did not contain any documentation of completing 16 hours of supervised training. C. On 05/02/24 at 3:29 pm, during an interview, the Program Director confirmed that DCS #5 had not completed 16 hours of supervised training and there was no documentation.	A 017		
A 025	7 NMAC 8.2.25 Resident Evaluation RESIDENT EVALUATION: A. A resident evaluation shall be completed by an appropriate staff member within fifteen (15) days prior to admission to determine the level of assistance that is needed and if the level of services required by the resident can be met by the facility. B. The initial resident evaluation shall establish a baseline in the resident ' s functional status and thereafter assist with identifying resident changes. The resident evaluation shall be reviewed and updated at a minimum of every six (6) months or when there is a significant change in the resident ' s health status. C. The resident ' s evaluation shall be documented on a resident evaluation form and at a minimum include the following abilities,	A 025		

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A 025	Continued From page 3 behaviors or status: (1) activities of daily living; (2) cognitive abilities; reasoning and perception; the ability to articulate thoughts, memory function or impairment, etc; (3) communication and hearing; ability to communicate needs and understand instructions, etc; (4) vision; (5) physical functioning and skeletal problems; (6) incontinence of bowel/bladder; (7) psychosocial well-being; (8) mood and behavior; (9) activity interests; (10) diagnoses; (11) health conditions; (12) nutritional status; (13) oral or dental status; (14) skin conditions; (15) medication use and level of assistance needed with medications; (16) special treatments and procedures or special medical needs such as hospice; and (17) safety needs/high risk behaviors; history of falls agitation, wandering, fire safety issues, etc. D. The resident evaluation shall include a history and physical examination and an evaluation report by a physician or a physician extender within six (6) months of admission. A resident shall have a medical evaluation by a physician or a physician extender at least annually. E. The resident evaluation shall be reviewed and if needed revised by a licensed practical nurse, registered nurse or physician extender at the time the individual service plan is reviewed, at a minimum of every six (6) months or when a significant change in health status occurs. [7.8.2.25 NMAC - Rp, 7.8.2.25 NMAC, 01/15/2010]	A 025		

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A 025	Continued From page 4 This REQUIREMENT is not met as evidenced by: 7.8.2.25 E Based on record review and interview, the facility failed to ensure for 2 (R #s 2 and 5) of 6 (R #s 1-5 and 9) residents whose evaluations were reviewed for compliance that: 1. A Licensed Practical Nurse (LPN), Registered Nurse (RN), or Physician Extender (PE) (A Physician Assistant or Nurse Practitioner) is reviewed or if needed revised the evaluations. 2. The resident evaluations were reviewed or if needed revised at least every six (6) months or when there is a significant change in the resident's health status. This deficient practice could likely result in the 38 (R #s 1-38) residents identified on the resident census provided by the Administrator on 04/29/24 not receiving appropriate care/services if the resident evaluations are not reviewed or revised by an LPN, RN, or PE, and the Direct Care Staff (DCS) are not aware of what the residents need. The findings are: A. Record review of R #2's (admission date [redacted] resident file revealed a LPN, RN, or PE did not review or if needed revise R #2's evaluation. B. Record review of R #5's (admission date [redacted] resident file revealed the last resident evaluation for R #5 was dated [redacted], was due	A 025	**7 NMAC 8.2.25** **Resident Evaluation** **RESIDENT EVALUATION:** The initial resident evaluation shall establish a baseline in the resident's functional status and thereafter assist with identifying resident changes. The resident evaluation shall be reviewed and updated at a minimum of every six (6) months or when there is a significant change in the resident's health status. (Resident records maintenance) Resident Health records and documentation of resident evaluations shall be maintained on-site by the Wellness Director to ensure ongoing compliance. The Wellness Director will be responsible for reviewing and revising evaluations at lease every 6 months or sooner if needed when the resident has a change in condition. The scheduled evaluations will be monitored by the Program Director to ensure ongoing compliance.	8/30/24

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A 025	Continued From page 5 to be updated September [redacted], however, no update as made. C. On 05/06/24 at 1:07 pm, during an interview, the Administrator confirmed that R #2 and R #5 evaluations were not being updated every six months.	A 025		
A 026	7 NMAC 8.2.26 Individual Service Plan INDIVIDUAL SERVICE PLAN (ISP): An ISP shall be developed and implemented within ten (10) calendar days of admission for each resident residing in the facility. A. The ISP shall address those areas of need as identified in the resident evaluation and through staff observation. (1) The ISP shall detail the services that are provided by the facility as well as the services to be provided by other agencies. (2) The resident evaluation and the ISP shall be reviewed and if needed revised by a licensed practical nurse, registered nurse or a physician extender. (3) The ISP shall be reviewed and or revised at a minimum of every six (6) months or when there is a significant change in the resident ' s health status. B. The ISP shall include the following: (1) a description of identified needs as noted in the resident evaluation; (2) a written description of all services to be provided; (3) who will provide the services; (4) when or how often the services will be provided; (5) how the services will be provided; (6) where the services will be provided; (7) expected goals and outcomes of the services;	A 026		

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A 026	Continued From page 6 (8) documentation of the facility ' s determination that it is able to meet the needs of the resident; (9) the level of assistance that the resident will require with activities of daily living and with medications; (10) a crisis prevention/intervention plan when indicated by diagnosis or behavior; and (11) current orders for all medications, including those authorized for PRN usage. [7.8.2.26 NMAC - Rp, 7.8.2.26 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.26 A 2 and 3 Based on record review and interview, the facility failed to ensure for 4 (R #2, R #5, R #6 and R #9) of 6 (R #s 1-5 and R #9) residents whose Individual Service Plans (ISP's) were reviewed for compliance that: 1. A Licensed Practical Nurse (LPN), Registered Nurse (RN), or a Physician Extender (PE) (A Physician assistant or Nurse Practitioner) reviewed or if needed revised the ISP's. 2. The ISP's were reviewed or if needed revised at least every six (6) months or when there is a significant change in the resident's health status. These deficient practices could likely result in the 38 (R #s 1-38) residents identified on the resident census provided by the Administrator on 04/29/24 being at risk of harm and not receiving the care and services needed if the ISP is not updated at least every six (6) months and reviewed/revised by an LPN, RN, or PE resulting in the DCS being unaware of the care and services needed by the	A 026	**7 NMAC 8.2.26** **Individual Service Plan** **INDIVIDUAL SERVICE PLAN (ISP):** An ISP shall be developed and implemented within ten (10) calendar days of admission for each resident residing in the community. A. The ISP shall address those areas of need as identified in the resident evaluation and through staff observation. (1) The ISP shall detail the services that are provided by the facility as well as the services to be provided by other agencies. (2) The resident evaluation and the ISP shall be reviewed and if needed revised by a licensed practical nurse, registered nurse or a physician extender. (3) The ISP shall be reviewed and or revised at a minimum of every six (6) months or when there is a significant change in the resident's health status	8/30/24

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A 026	Continued From page 7 resident. The findings are: A. Record review of R #2's resident file (admission date [redacted] revealed R #2's ISP dated [redacted] was due to be updated March [redacted], however, no update was made. B. Record review of R #5's resident file (admission date [redacted] revealed R #5's ISP dated [redacted] was due to be updated September [redacted] however, no update was made. C. Record review of R #6's resident file (admission date [redacted] revealed a LPN, RN, or a PE did not review or if needed revise the ISP dated [redacted] D. Record review of R #9's resident file (admission date [redacted] revealed a LPN, RN, or a PE did not review or if needed revise the ISP dated [redacted] E. On 05/06/24 at 1:07 pm, during an interview, the Administrator confirmed: 1. R #2 and R #5's ISP's were not updated every six months. 2. If needed, An LPN, RN, or PE did not review, revise ISP's for R #6 and R #9	A 026	(Resident records maintenance) Resident Health records and documentation of resident ISP's shall be maintained on-site by the Wellness Director to ensure ongoing compliance. The Wellness Director will be responsible for reviewing and revising ISP's at lease every 6 months or sooner if needed when the resident has a change in condition. The scheduled ISP's will be monitored by the Program Director to ensure ongoing compliance.	8/30/24
A 032	7 NMAC 8.2.32 Reporting of Incidents REPORTING OF INCIDENTS: A. The facility shall insure that all suspected cases or known incidents of resident abuse, neglect or exploitation are reported in accordance with 7.1.13 NMAC. (1) The facility shall also report any incident or unusual occurrence which has or could threaten the health, safety, or welfare of the residents and	A 032		

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A 032	Continued From page 8 staff to the licensing authority complaint hotline within twenty-four (24) hours or by the next business day, if it is a weekend or a holiday. (2) The facility shall not delay a report to the complaint hotline while an internal investigation is conducted. B. The facility is responsible for conducting and documenting the investigation of all incidents within five (5) business days and shall submit a copy of the investigation report to the licensing authority. A copy of the report and the documentation, including the date and time that it was submitted to the licensing authority, shall be maintained on file at the facility. The investigation shall include the following: (1) a narrative description of the incident; (2) the result of the facility's investigation shall be recorded on the state approved incident report form for the current year, pursuant to 7.1.13 NMAC; and (3) plans for further actions in response to the incident. [7.8.2.32 NMAC - Rp, 7.8.2.32 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.32 A (1) 7.1.13 INCIDENT REPORTING, INTAKE, PROCESSING AND TRAINING REQUIREMENTS Refer to 7.1.13.7 W. and 8 B. (2) W. "Reportable incident" means possible abuse, neglect, exploitation, injuries of unknown origin and other events including but not limited to falls	A 032	**7 NMAC 8.2.32** **Reporting of Incidents** **REPORTING OF INCIDENTS:** The Program Director shall ensure that all suspected cases or known incidents of resident abuse, neglect or exploitation are reported in accordance with 7.1.13 NMAC. The Program Director shall also report any incident or unusual occurrence which has or could threaten the health, safety, or welfare of the residents and staff to the licensing authority complaint hotline within twenty-four (24) hours or by the next business day, if it is a weekend or a holiday. The Program Director shall not delay a report to the complaint hotline while an internal investigation is conducted. (Resident records maintenance) Resident Health records and documentation of resident incident reports shall be maintained, reviewed and audited on-site monthly by the Program Director to ensure ongoing compliance.	8/30/24

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A 032	Continued From page 9 which cause injury, unexpected death, elopement, medication error which causes or is likely to cause harm, failure to follow a doctor's order or an ISP or any other incident which may evidence abuse, neglect, or exploitation. B. (2) Division incident report form and notification by licensed health care facilities: The licensed health care facility shall report incidents utilizing the division's incident report form consistent with the requirements of the division's incident management system guide and CMS regulations as applicable. The licensed health care facility shall ensure that all incident report forms alleging abuse, neglect, exploitation, injuries of unknown origin or other reportable incidents are submitted by a reporter with direct knowledge of an incident, are completed on the bureau's incident report form and received by the division within twenty-four (24) hours of an incident or allegation of an incident or the next business day if the incident occurs on a weekend or a holiday. The licensed health care facility shall ensure that the reporter with the most direct knowledge of the incident assists with the preparation of the incident report form. Based on record review and interview, the facility failed to ensure for 1 (R #12) of 13 (R #'s 1-13) residents whose internal (facility-created) incident Reports were reviewed for compliance that the facility-reported incidents of suspected abuse which had or could threaten the health, safety, or welfare of the residents and staff to the Licensing Authority within twenty-four (24) hours or by the next business day if it is a weekend or a holiday. This deficient practice could likely result in the 38 (R #s 1-38) residents listed on the resident census provided by the Administrator on	A 032		

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A 032	Continued From page 10 04/29/24, to be at risk of harm, injury, and/or death if there is suspected abuse and it is not reported to the Licensing Authority. The findings are: A. Record review of complaint intake NM [redacted] (reported by an anonymous complainant) showed: 1. On [redacted]24, it was reported that R #12 had marks on [redacted] face and possible bruises on [redacted] back when [redacted] did not have any marks on the previous day. 2. DCS #1 (Direct Care Staff) had scratch marks on [redacted] arm the same afternoon. 3. DCS #12 was across the hall from R #12's room and could hear DCS #1 hitting and verbally abusing R #12. B. On [redacted]/24 at 11:00 am, during an interview, DCS #12 stated that he believed that DCS #1 verbally and physically abused R #12 and that he reported it to the Program Director but could not recall the date reported. DCS #12 stated that he also reported the suspected abuse to Human Resources (HR) on an unknown date after he reported it to the Program Director. C. On 05/07/24, at 3:50 pm, during an interview, the Program Director confirmed: 1. DCS #12 suspected DCS #1 of abusing R #12 and reported it to her verbally, seven (7) days after the incident. 2. An internal investigation was completed by the Program Director on 02/27/24 with no findings of abuse. 3. The facility conducted an internal investigation of suspected abused by DCS #1, and it was not reported to the Licensing Authority.	A 032		

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A 033	Continued From page 11	A 033		
A 033	7 NMAC 8.2.33 Resident Rights RESIDENT RIGHTS: All licensed facilities shall understand, protect and respect the rights of all residents. A. Prior to admission to a facility, a resident and legal representative shall be given a written description of the legal rights of the resident, translated into another language, if necessary, to meet the resident ' s understanding. B. If the resident has no legal representative and is incapable of understanding his or her legal rights, a written copy of the resident's legal rights shall be provided to the most significant responsible party in the following order: (1) the resident's spouse; (2) significant other; (3) any of the resident's adult children; (4) the resident's parents; (5) any relative the resident has lived with for six or more months before admission; (6) a person who has been caring for, or paying benefits on behalf of the resident; (7) a placing agency; (8) resident advocate; or (9) the ombudsman. C. The resident rights shall be posted in a conspicuous public place in the facility and shall include the telephone numbers for the incident management hotline and for the state ombudsman program. D. To protect resident rights, the facility shall: (1) treat all residents with courtesy, respect, dignity and compassion; (2) not discriminate in admission or services based on gender, sexual orientation, resident's age, race, religion, physical or mental disability, or nationality; (3) provide residents written information about all	A 033		

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A 033	Continued From page 12 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: (a) are free from physical and emotional abuse neglect and misappropriation/or exploitation; (b) are free from financial abuse and misappropriation by facility staff or management; (c) are free to participate in religious, social, community and other activities and freely associate with persons in and out of the facility; (d) are free to leave the facility and return without unreasonable restriction; (e) are given a fifteen (15) calendar day, written notice before room transfers or discharge from the facility unless there is immediate danger to self or others in the facility; (f) have an environment that fosters social interaction and avoids social isolation; (g) or their surrogate decision makers, are	A 033		

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A 033	Continued From page 13 informed of and consent to the services provided by the facility; (h) have the right to voice grievances to the facility staff, public officials, the ombudsmen, any state agency, or any other person, without fear of reprisal or retaliation; (i) have the right to have their complaints addressed within fourteen (14) calendar days or sooner; (j) have the right to participate in the development of their care plan/ISP; (k) have the right to choose a doctor, pharmacist and other health care provider(s); (l) have the right to participate in medical treatment decisions and formulate advance directives such as living wills and powers of attorney; (m) have the right to keep and use personal possessions without loss or damage; (n) have the right to manage and control their personal finances; (o) have the right to freely organize and participate in a resident association that may recommend changes in the facility's policies, services and management; (p) shall not be required to work for the facility; and (q) are protected from unjustified room transfers or discharge. E. The resident's rights shall not be restricted unless this restriction is for the health and safety of the resident, agreed to by the resident or the resident ' s surrogate decision maker and outlined in the resident ' s individual service plan. [7.8.2.33 NMAC - Rp, 7.8.2.34 NMAC, 01/15/2010]	A 033		

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A 033	Continued From page 14 This REQUIREMENT is not met as evidenced by: 7.8.2.33 D (7)(9) Based on observation, record review, and interview, the facility failed to ensure: 1. Residents had the right to communicate privately and have private telephone conversations. 2. The resident's confidentiality of their medical records is protected. These deficient practices could likely affect the safety and welfare of the 38 (R #s 1-38) residents identified on the resident census provided by the Administrator on 04/29/24, if: 1. The residents are unable to speak freely, and their rights are being violated. 2. Unauthorized person given resident's private information. The findings are: Right to Privacy: A. Record review of New Mexico Department of Health (NMDOH) Complaint Intake NM[redacted] received on [redacted]'24, revealed that the Complainant reported the following: 1. The nurses's station is the only place where residents can use the phone for private conversations. B. On 04/29/24 at 10:44 am, during an observation of the facility's north resident wing, revealed: 1. A nursing station desk countertop has a telephone located behind it. 2. The nursing station does not allow residents to have private telephone	A 033	**7 NMAC 8.2.33** **Resident Rights** **RESIDENT RIGHTS:** All staff shall understand, protect and respect the rights of all residents. To protect resident rights, the Program Director shall: 1. Ensure residents have the designated telephone and location to communicate privately and have private telephone conversations. 2. An all staff training will be provided by the Program Director on how to ensure the resident's confidentiality of their medical records is protected. (Employee records maintenance) Employee personnel records and documentation of Orientation and subsequent trainings related to HIPPA shall be maintained, reviewed and audited monthly on-site by the Program Director to ensure ongoing compliance.	8/30/24

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A 033	Continued From page 15 conversations. C. On 04/29/24 at 11:40 am, during an observation of the facility's south resident wing, revealed: 1. A nursing station desk countertop has a telephone located behind it. 2. The nursing station does not allow residents to have private telephone conversations. D. On 05/02/24 at 11:40 am, during an interview the program director confirmed: 1. Residents use the nursing station phone to make private phone calls. 2. Residents use the Med-Techs (a Direct Care Staff/DCS who can assist with the self-administration of medications) work issued cell phone and sit in the outskirts (outlying public area) in the common area if requested. 3. No private area or phone designated for residents to have private phone calls. Resident confidentiality: E. On 05/02/24 at 2:27 pm, during an interview, R #4's Power of Attorney (POA) revealed on 04/21/24: 1. She was notified by the [name of local police department] an unauthorized person (not R #4's medical provider or POA) received information that R #4 was no longer living at the facility, and R #4 was moved to another facility. 2. DCS #11 told her (R #4's POA), DCS #10 disclosed to the unauthorized person R #4 is at another facility. F. On 05/03/24 at 10:21 am, during an interview, DCS #10 stated he could not recall talking to an unauthorized person about R #4.	A 033		

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A 033	Continued From page 16 G. On 05/06/24 at 12:19 pm, during an interview, DCS #11 revealed that DCS #10 disclosed to her that he told an unauthorized person R #4 was no longer at the facility and R #4 is now at another facility. H. On 05/06/2024 at 1:11 pm, during an interview with the Administrator, he confirmed that DCS #10 provided R #4's confidential information to an unauthorized person.	A 033		
A 034	7 NMAC 8.2.34 Custodial Drug Permits CUSTODIAL DRUG PERMITS: A facility with two (2) or more residents that is licensed pursuant to this rule and that assists with self-administration or safeguards medications for residents shall have a current custodial drug permit issued by the state board of pharmacy. A. Procurement, labeling and storage. The facility shall provide assistance to the resident in obtaining the necessary medications, treatment and medical supplies as identified in the ISP. The facility shall procure, label and store medications for residents who require assistance with self-administration of medication in compliance with state and federal laws. (1) All medications, including non-prescription drugs, shall be stored in a locked compartment or in a locked room, as approved by the board of pharmacy and the key shall be in the care of the administrator or designee. (2) Internal medication shall be kept separate from external medications. Drugs to be taken by mouth shall be separated from all other delivery forms. (3) A separate, locked refrigerator shall be provided by the facility for medications. The	A 034		

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A 034	Continued From page 17 refrigerator temperature shall be kept in compliance with the state board of pharmacy requirements for medications. (4) All medications, including non-prescription medications, shall be stored in separate compartments for each resident and all medications shall be labeled with the resident's name. (5) A resident may be permitted to keep his or her own medication in a locked compartment in his or her room for self-administration, if the physician's order deems it appropriate. (6) The facility shall not require the residents to purchase medications from any particular pharmacy. (7) Medical gases (oxygen) and equipment used for the administration of inhalation therapy and for resuscitative purposes shall comply with the national fire protection association (NFPA) 99. (8) A proof of use record shall be maintained separately for each schedule II through IV drug (controlled substances). The proof of use sheet shall document: (a) the type and strength of the schedule II through IV drugs; (b) the date and time staff assisted with self-administration; (c) the resident ' s name; (d) the prescriber ' s name; (e) the dose; (f) the signature of the person assisting with delivery of the medication; and (g) the balance of medication remaining. (9) Any remaining medication discontinued by a physician ' s order, or upon discharge or death of the resident shall be inventoried and moved to a separate locked storage container. Such discontinued medications shall be destroyed upon the next quarterly visit by the consulting	A 034		

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A 034	Continued From page 18 pharmacist in accordance with 16.19.11.10 NMAC. (10) The record of medication destruction shall be signed by the administrator or designee and the pharmacist and shall be kept on file at the facility. B. Consulting pharmacist. The facility shall maintain records demonstrating that the consulting pharmacist provides the following oversight and guidance. (1) Reviews the medication regimen as needed, but at least quarterly/every three (3) months, to determine that all medications and records are accurate and current. All irregularities shall be reported to the administrator of the facility and these irregularities shall be resolved by the administrator within seventy-two (72) hours. (2) A system of records of receipt and disposition of all drugs in sufficient detail to enable an accurate reconciliation. (3) Consultation shall be provided on all aspects of pharmacy services in the facility, including reference information regarding side effects and, when needed, physician consultation in cases involving the use of psychotropic medications. (4) The consulting pharmacist will be responsible for assuring that the facility meets all requirements for storage, labeling, destruction and documentation of medications as required by the state board of pharmacy, 16.19.11.10 NMAC and 7.8.2 NMAC. [7.8.2.34 NMAC - Rp, 7.8.2.35 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.34 A Based on record review and interview, the facility	A 034	**7 NMAC 8.2.34** **Custodial Drug Permits** **CUSTODIAL DRUG PERMITS:** Staff training, for any staff handling medications (and staff scheduling those handling medications), will be provided by the Program Director on how to ensure the resident's medication is available to take as ordered and delivered in a timely manner. Med techs will be responsible for ensuring scheduled and PRN medications are available to take as ordered. (Employee records maintenance) Employee personnel records and documentation of Orientation and subsequent trainings related to medication management shall be maintained on-site by the Program Director to ensure ongoing compliance. The Program Director will be responsible for reviewing and updating the employee weekly schedules and as needed to ensure adequate staffing is available to assist with medications.	8/30/24

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A 034	Continued From page 19 failed to ensure that for 1 (R #1) of 38 (R #1-38) residents whose facility records were reviewed for compliance had their prescribed medications available to take as ordered. This deficient practice could potentially affect the health, safety, and welfare of the 38 (R #s 1-38) residents (listed on the census provided by the Administrator on 04/29/24 at 3:00 pm) if the resident miss a dose of their prescribed medications. The findings are: A. On 05/02/24 at 10:00 am, during an interview with the personal caregiver, they stated that On 03/11/24, they noticed changes in R #1. The resident was acting [redacted] than was usual, and resident was doing less physically during the day. The resident also went to bed earlier during the week than they had previously. The personal caregiver and complainant contacted the [redacted] provider. Thei[redacted] provider was able to meet them along with the program director of the memory care facility. The [redacted] Nurse brought R #1 an [redacted]. This package was to be stored in the med-tech closet, (a secured room where resident medications are stored). B. On 04/29/24 at 3:27 pm, during an interview with the complainant, they confirmed: 1. They received a phone call from R #1's personal caregiver(Privately compensated individual that is not employed at the facility), at	A 034		

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A 034	Continued From page 20 about 4:50 am or [redacted] alerting them that R #1 was [redacted] and that there was no staff around on the unit. 2. The complainant arrived at the memory care unit at about 5:07 am. The complainant met with R #1's personal caregiver and the two went to find the staff on the floor to request a PRN (medication that are prescribed to be taken as needed, rather than following a fixed daily schedule) from the [redacted] for R #1. 3. The personal caregiver and complainant found Direct Care Staff (DCS) #14 assigned to the unit asleep and woke them up to request the PRN. DCS #14 was not a med-tech (Medication Technician, A staff who assists with the self-administration of medications) and could not access or administer the medications to R #1. 4. The complainant called the administrator and left a voicemail, as well as called and left a voicemail with the Program Manager. The complainant also called out to the [Name of Local Police Department] for aid but was not provided with any solutions for this incident. 5. DCS #14 left to the other side of the memory care unit to help the other staff with tasks since they were not a med-tech and could not administer medication. 6. Just after 6:00 am, staff from the assisted living facility came to the memory care unit and needed the administrator's help to locate the keys to the medication closet. They could open the closet and retrieve the medications for R #1. C. Record review, R #1 MAR (Medication Administration Record, a document used to record medications taken by each individual) and medication exception sheet (A document that documents any medication refusal or reason(s)	A 034		

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A 034	Continued From page 21 that medication was given.) for the month of April 2024, R #1 was given [redacted] 6:27 am. At 8:25 am, R #1 was given another dose [redacted] D. On 05/08/24 at 10:01 am, during an interview, DCS #2 confirmed: 1. On the morning of 03/12/24, DCS #14 from memory care unit called just before 5:00 am and stated that R #1 requested [redacted] for pain. About 10-15 minutes later, DCS #14 called again, stating R #1 was now requesting their [redacted] DCS #2 alerted the staff that they would be on site shortly to administer. 2. DCS #3 had a call into the facility and was not replaced with another staff member to float. (working between units as needed) between the units since each wing of the memory care unit had one staff on each side, and coverage was considered adequate. 3. The facility call-in policy states that a DCS must call the facility at least four (4) hours before their assigned shift starts. If the DCS slot isn't covered, the on-call manager is to cover it. 4. DCS #3 was absent from the memory care floor on the grave yard shift that morning, so the unit was without an assigned med-tech, and R #1 was unable to receive their PRN medication at the time of request. E. On 04/30/24 at 2:22 pm, during an interview, the Program Director confirmed: 1. On the morning of 03/12/24. They (the Program Director) called the On-call manager and nurse to locate someone to deliver the PRN medication to R #1.	A 034		

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A 034	Continued From page 22 2. An on-call nurse called for a med-tech to come up the hill to the memory care unit to administer PRN medications to R #1 on the assisted living side of the facility. 3. On 03/12/24, post incident, they met with [redacted] Nurse and the family for R #1 to grant permission for R #1 to keep a lock box with the [redacted] kept in their apartment and the personal caregiver for the duration of R #1's stay at the facility. 4. The Program Director creates the schedule with the administrator and managers. The facility protocol is for DCS to contact the on-call manager first. The manger reaches out to fill the shift accordingly. The on-call manager must cover the shift if it cannot be filled. F. On 05/06/24 at 1:00 pm, during an interview with the Administrator, they confirmed the following: 1. On the morning of 03/12/24, there was a shortage of med tech staff on the south side of the memory care unit. 2. The med-tech absence left the facility unable to provide PRN medications to R #1 at the time of their request. 3. A med-tech was called from the assisted living facility down the hill from the memory care unit to administer the PRN to R #1 over an hour after it was requested.	A 034		
A 036	7 NMAC 8.2.36 Nutrition NUTRITION: The facility shall provide planned and nutritionally balanced meals from the basic food groups in accordance with the " recommended daily dietary allowance " of the American dietetic association, the food and nutrition board of the national research council, or	A 036		

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A 036	Continued From page 23 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. A. Dietary services policies and procedures. The facility will develop and implement written policies and procedures that are maintained on the premises and that govern the following requirements. (1) Meal service. The facility shall: (a) serve at least three (3) meals or their equivalent each day at regular times with no more than sixteen (16) hours between the evening meal and morning meal with snacks freely available; (b) provide snacks of nourishing quality and post on the daily menu; (c) develop menus enjoyed by the residents and served at normal intervals appropriate to the residents ' preferences; (d) post the weekly menu, including snacks where residents and families are able to view it; posted menus shall be followed and any substitution shall be of equivalent nutritional value and recorded on the posted menu; identical menus shall not be used within a one (1) week cycle; (e) have special menus or meal items following guidelines from the resident ' s physician for residents who have medically prescribed special diets; (f) serve all residents in a dining room except for residents with a temporary illness, or with documented specific personal preference to have meals in their room; (g) allow sufficient time for meals to enable residents to eat at a leisurely pace and to socialize; and	A 036		

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A 036	Continued From page 24 (h) contact the resident ' s PCP within forty-eight (48) hours if a resident consistently refuses to eat. (2) Staff in-service training. The facility shall provide an in-service training program for staff that are involved in food preparation at orientation and at least annually and that includes: (a) instruction in proper food storage; (b) preparation and serving food; (c) safety in food handling; (d) appropriate personal hygiene; and (e) infectious and communicable disease control. B. Dietary records. The facility shall maintain the following documentation onsite: (1) a systematic record of all menus and revisions, including snacks, for a minimum of thirty (30) calendar days; (2) a systematic record of therapeutic diets as prescribed by a PCP; (3) a copy of the most recent licensing inspection and for facilities with 10 or more residents, a copy of the New Mexico environment department inspection with notations made by the facility of action taken to comply with recommendations or citations; and (4) a daily log of the recorded temperatures for all facility refrigerators, freezers and steam tables maintained and available for inspection for thirty (30) calendar days. C. Clean and sanitary conditions. All practices shall be in accordance with the standards of the state environment department, pursuant to 7.6.2 NMAC. (1) Kitchen sanitation. (a) Equipment and work areas shall be clean and in good repair. Surfaces with which food or beverages come into contact shall be of smooth, impervious material free of open seams, not readily corrodible and easily accessible for	A 036		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 036	Continued From page 25 cleaning. (b) Utensils shall be stored in a clean, dry place protected from contamination. (c) The walls, ceiling and floors of all rooms that food or drink is stored, prepared or served shall be kept clean and in good repair. (2) Washing and sanitizing kitchenware. (a) All reusable tableware and kitchenware shall be cleaned in accordance with procedures that include separate steps for prewashing, washing, rinsing and sanitizing. (b) Proper dishwashing procedures and techniques shall be utilized and understood by the dishwashing staff. (c) Periodic monitoring of the operation of the detergent dispenser, washing, rinsing and sanitizing temperatures shall be performed and documented. (d) When a dishwashing machine is utilized, the cleanliness of the machine, its jets and its thermostatic controls shall be monitored and documented by the facility. A monthly log of the recorded temperature of the dishwasher shall be maintained in the facility and available for inspection. (3) Sinks for hand washing shall include hot and cold running water, hand-washing soap and disposable towels. (4) All garbage and kitchen refuse that is not disposed of through a garbage disposal unit shall be kept in watertight containers with close-fitting covers and disposed of daily in a safe and sanitary manner. (5) Cooks and food handlers shall wear clean outer garments and hair nets or caps and shall keep their hands clean at all times when engaged in handling food, drink, utensils or equipment in accordance with the local health authority. Disposable gloves shall be used in accordance	A 036		

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A 036	Continued From page 26 with the local health authority. 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, 7.6.2 NMAC. (1) The facility shall ensure that a minimum of a three (3) calendar day supply of perishables and a five (5) calendar day supply of non-perishables or canned foods is available for the residents. (2) The facility refrigerator and freezer shall have an accurate thermometer which reads within or not more than plus or minus three (3) degrees fahrenheit of the required temperature, located in the warmest section of the refrigerator and freezer and shall be accessible and easily read. (a) The temperature of the refrigerator shall be thirty-five (35) - forty-one (41) degrees fahrenheit. (b) Freezer temperatures shall be maintained at zero (0) degrees fahrenheit or below. (3) Refrigerators and freezers shall be kept clean and sanitary at all times. Food stored in refrigerators and freezers shall be covered, dated and labeled. Unused leftover food shall be discarded after three (3) calendar days. (4) Steam tables, hot food tables, slow cookers, crock pots and other hot food holding devices shall not be used in heating or reheating food. Hot food temperatures shall be checked periodically to insure that a minimum of one hundred forty (140) degrees fahrenheit is maintained. (5) Medication, biological specimens, poisons, detergents and cleaning supplies shall not be kept in the same storage areas used for storage of foods. Medications shall not be stored in the refrigerator with food; an alternate refrigerator for medication shall be used pursuant to Subsection B of 7.6.2.8 NMAC.	A 036		

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A 036	Continued From page 27 (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. (7) Dry or staple food items shall be stored at least six (6) inches off the floor in a ventilated room that is not subject to sewage, waste water back-flow or contamination by condensation, leakage, rodents or vermin. (8) The facility shall ensure the following: (a) all perishable food is refrigerated and the temperature is maintained no higher than forty-one (41) degrees fahrenheit; (b) the temperature for all hot foods is maintained at one hundred forty (140) degrees fahrenheit; and (c) all displayed or transported food is protected from environmental contamination and maintained at proper temperatures in clean containers, cabinets or serving carts. E. Milk. (1) Raw milk shall not be used. (2) Condensed, evaporated, or dried milk products that are nationally recognized may be employed as " additives " in cooked food preparation but shall not be substituted or served to residents in place of milk. F. Collateral requirements. Compliance with this rule does not relieve a facility from the responsibility of meeting more stringent municipal regulations, ordinances or other requirements of state or federal laws governing food service establishments. Local health authority having jurisdiction means municipal, county, state or federal agency(s) that have laws and regulations governing food establishments, liquid waste disposal, treatment facilities and private wells. [7.8.2.36 NMAC - Rp, 7.8.2.37 NMAC,	A 036		

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A 036	Continued From page 28 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.36 D (3) Based on record review, observation, and interview, the facility failed to ensure: 1. That food stored in refrigerators and freezers was covered, dated, labeled, and any unused leftover foods were discarded after three (3) calendar days. 2. That the residents received nutritionally balanced meals in accordance with the recommended daily dietary allowance. These deficient practices could likely result in the 38 (R #s 1-38) residents listed on the census provided by the Administrator on 04/29/24, to be at risk of harm or contracting foodborne illnesses if: 1. Food was not stored properly (dated, labeled), and leftovers were kept longer than (3) three days after being served the 1st time. 2. Residents are not aware of what they are choosing to eat and if the food is meeting their nutritional needs. The findings are: A. On 04/29/24 at 10:30 am, during an observation of the refrigerator located in the South-Wing kitchenette near the nurses station, the following was observed: 1. Two (2) undated/unlabeled and uncovered pitchers of juice. 2. Fourteen (14) 4 oz (ounces) containers of expired yogurts, with the following expiration	A 036	**7 NMAC 8.2.36** **Nutrition** **NUTRITION:** The Program Director shall provide an in-service training for staff that are involved in food preparation that includes: 1. That food stored in refrigerators and freezers is covered, dated, labeled, and any unused leftover foods are discarded after three (3) calendar days. Daily refrigerator inspections of all stored food will be performed by staff involved in food storage or preparation. 2. That the residents receive nutritionally balanced meals in accordance with the recommended daily dietary allowance. (Employee records maintenance) Employee personnel records and documentation of Orientation and subsequent trainings related to proper storage and destruction of food as needed shall be maintained on-site by the Program Director. To ensure ongoing compliance all staff handling food will be responsible for properly storing food and serving balanced meals in accordance with the recommended daily dietary allowance.	8/30/24

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A 036	Continued From page 29 dates: a. 03/11/24 b. 04/22/24 3. One (1) 5.3 oz container of expired (12/29/23) yogurt. 4. Four (4) 8 fl oz (fluid ounce) carton of expired (04/22/24) milk. 5. One (1) unknown size bowl of expired (04/14/24) macaroni. 6. One (1) undated/unlabeled moldy (fungal growth) cooked potato. B. On 04/29/24 at 10:36 am, during an interview with DCS #13, she confirmed the food and drinks stored in the refrigerator located in the South-Wing kitchenette near the nurses station are: 1. For resident use. 2. Not stored properly (undated, unlabeled, and expired). C. On 04/29/24 at 10:46 am, during an observation of the refrigerator located in the North-Wing Kitchenette near room #28, the following was observed: 1. Twenty-seven (27) 11 fl oz bottles of expired nutritional shakes. 2. One (1) 11 lb tub of expired chocolate icing. 3. One (1) 1.5 oz expired cheese, cashews and raisins. D. On 04/29/24 at 10:51 am, during an interview with the Executive Director, he confirmed the refrigerators located in both the South and North wing of the facility have food and drinks that are not being stored properly (undated, unlabeled, uncovered and expired). E. On 04/29/24 at 10:52 am, during an	A 036		

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A 036	Continued From page 30 observation of the refrigerator located in the North-Wing Kitchenette near the nurses station, the following was observed: 1. Three (3) 11 fl oz bottles of expired (02/29/24) nutritional shakes. 2. One (1) undated/unlabeled and uncovered cake portion. 3. One (1) unknown size bowl of undated/unlabeled diced watermelon. 4. One (1) unknown size bottle of undated/unlabeled liquid. F. On 04/29/24 at 10:58 am, during an observation of the refrigerator located in the North-Wing dining area revealed the following: 1. Five (5) undated/unlabeled and uncovered pitchers of juice. 2. One (1) undated/unlabeled portion of cake. G. On 04/29/24 at 12:08 pm, during record review, Surveyor reviewed staff files for certifications. Kitchen Staff #1 received a write up that stated the meal served was not at temperature, did not adhere to dietary guidelines, and that portion size served to the resident was inappropriate. The photo retained in the file matched complainant's picture of the reported meal. H. On 05/06/24 at 1:00 pm during survey team interview with Administrator, he confirmed that Kitchen Staff #1 was written up for substandard performance and provided meals to resident #1 that did not meet dietary guidelines and were under portioned.	A 036		
A 069	7 NMAC 8.2.69 Memory Care Units	A 069		

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A 069	Continued From page 31 MEMORY CARE UNITS: An assisted living facility that provides a memory care unit to serve residents with dementia shall comply with the provisions of subsection A-J below in addition to the rules applicable to all assisted living facilities, 7.8.2 NMAC. A. Additional definitions: The following definitions, in addition to those in 7.8.2.7 NMAC, shall apply. (1) " Alzheimer ' s " means a brain disorder that destroys brain cells, causing problems with memory, thinking and behavior that are severe enough to affect work, lifelong hobbies or social life. Alzheimer ' s gets progressively worse and is fatal. (2) " Care coordination agreement requirement " means a written document that outlines the care and services that are provided by other outside agencies for assisted living residents that require additional care and services. (3) " Dementia " means loss of memory and other mental abilities severe enough to interfere with daily life. It is caused by changes in the brain. (4) " Memory care unit " means an assisted living facility or part of or an assisted living facility that provides added security, enhanced programming and staffing appropriate for residents with a diagnosis of dementia, Alzheimer ' s disease or other related disorders causing memory impairments and for residents whose functional needs require a specialized program. (5) " Secured environment " means locked (secured/monitored) doors/fences that restrict access to the public way for residents who require a secure unit. B. Care coordination requirement. An assisted living facility that accepts residents with memory issues shall determine which additional services and care requirements are relevant to the	A 069		

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A 069	Continued From page 32 resident and disease process. (1) The medical diagnosis and ISP shall be utilized in the determination of the need for additional services. (2) The assisted living facility shall ensure the coordination of services and shall have evidence of an agreement of care coordination for all services provided in the facility by an outside health care provider. C. Employee training. In addition to the training requirements for all assisted living facilities, pursuant to 7.8.2.17 NMAC, all employees assisting in providing care for memory unit residents shall have a minimum of twelve (12) hours of training per year related to dementia, Alzheimer ' s disease, or other pertinent information. D. Individual service plan (ISP). An assisted living facility that admits memory care unit residents shall create an ISP in coordination with the resident ' s primary care practitioner, in compliance with the requirements outlined in " Individual Service Plan, " 7.8.2.26 NMAC, pursuant to a team meeting as described in " Exceptions to admission, readmission and retention, " Subsection C of 7.8.2.20 NMAC, and which ensures the following criteria: (1) identification of the resident's needs specific to the memory care unit and the services that are provided; each memory unit resident shall receive the services necessary to meet the individual resident ' s needs; (2) medications shall be self-administered, self-administered with assistance by an individual that has completed a state approved program in medication assistance or administered by the following individuals: (a) a physician; (b) a physician extender (PA or NP);	A 069		

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A 069	Continued From page 33 (c) a licensed nurse (RN or LPN); (d) the resident if their PCP has approved it; (e) family or family designee; and (f) any other individual in accordance with applicable state and local laws. E. Assessments and reevaluations. (1) An assessment shall be completed by a registered nurse or a physician extender within fifteen (15) days prior to admission. When emergency placement is warranted the fifteen (15) day assessment shall be waived and the assessment shall be completed within five (5) days after admission. (a) The resident shall have a medical evaluation and documentation by a physician, physician's assistant or a nurse practitioner within six (6) months of admission. (b) The pre-admission assessment shall include written findings, an evaluation of less restrictive alternatives and the basis for the admission to the secured environment. The written documentation shall include a diagnosis from the resident's PCP of Alzheimer's disease or other dementia and the need for the resident to reside in a memory care unit. (c) Only those residents who require a secured environment placement or whose needs can be met by the facility, as determined by the assessment prior to admission or on review of the individual service plan (ISP), shall be admitted. (2) A re-evaluation must be completed every six (6) months and when there is a significant change in the medical or physical condition of the resident that warrants intervention or different care needs, or when the resident becomes a danger to self or others, to determine whether the resident ' s stay in the assisted living facility memory care unit is still appropriate.	A 069		

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A 069	Continued From page 34 F. Documentation in the resident ' s record. In addition to the required documentation pursuant to 7.8.2.21 NMAC, the following information shall be documented in the resident ' s record: (1) the physician ' s diagnosis for admission to a secure environment or a memory care unit; (2) the pre-admission assessment; and (3) the re-evaluation(s). G. Secured environment. (1) Memory care unit residents may require a secure environment for their safety. A secured environment is any locked (secured/monitored) area in which doors and fences restrict access to the public way. These include but are not limited to: (a) double alarm systems; (b) gates connected to the fire alarm; and (c) tab alarms for residents at risk for elopement. (2) In addition to the interior common areas required by this rule, the facility shall provide a safe and secure outdoor area for the year round use by the residents. (a) Fencing or other enclosures shall prevent elopement and protect the safety and security of the residents. (b) Residents shall be able to independently access the outdoor areas. (3) Locked areas shall have an access code or key which facility employees shall have available on their person or on the locking unit itself at all times. H. Resident rights. In addition to the requirements pursuant to 7.8.2.32 NMAC, the following shall apply: (1) the resident's rights may be limited as required by their condition and as identified in the ISP; (2) the resident who believes that he or she has been inappropriately admitted to the secured	A 069		

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A 069	Continued From page 35 environment may request the facility in contact the resident ' s legal guardian, or an advocate such as the ombudsman or the primary care practitioner; upon request, the facility shall assist the resident in making such contact. I. Disclosure to residents. A facility that operates a secured environment shall disclose to the resident and the resident ' s legal representative, if applicable and prior to the resident ' s admission to the facility, that the facility operates a secured environment. (1) The disclosure shall include information about the types of resident diagnosis or behaviors that the facility provides services for and for which the staff are trained to provide care for. (2) The disclosure shall include information about the care, services and the type of secured environment that the facility and trained staff provide. J. Staffing. The facility shall provide the sufficient number of trained staff members to meet the additional needs of the residents in the secured environment. There must be at least one (1) trained staff member awake and in attendance in the secured environment at all times. [7.8.2.69 NMAC - N, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.69 J Based on record review and interview, the facility failed to ensure there was a sufficient number of trained staff on duty to meet the needs of the residents in the Memory Care Unit (MCU) and that they received their medications on time. This deficient practice could likely negatively affect the safety and welfare of the 38 (R #s 1-38)	A 069	**7 NMAC 8.2.69** **Memory Care Units** **MEMORY CARE UNITS:** The community shall ensure there is a sufficient number of trained staff on duty to meet the needs of the residents in the Memory Care Unit (MCU). Staff training, for any staff handling medications (and staff scheduling those handling medications), will be provided on how to ensure the resident's medication is available to take as ordered and delivered in a timely manner. (Employee records maintenance) Employee personnel records and documentation of Orientation and subsequent trainings related to medication management and meet the needs of the residents shall be maintained on-site by the Program Director. To ensure ongoing compliance, the Program Director will be responsible for reviewing and updating the employee weekly schedules and as needed to ensure adequate staffing is available to assist with medications and meet the needs of the residents.	8/30/24

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A 069	Continued From page 36 MCU residents listed on the census list provided by the Executive Director on 04/29/24, to be at risk of harm or injury if there is not adequate staffing to ensure residents receive their medications timely. The findings are: A. Record review of the Facility staffing schedule on 03/11/24 revealed there were three (3) graveyard (10:30 pm-6:30 am) staff scheduled for the shift in total: one for the northside of the memory care and one for the southside of the memory care, with one float staff (working between units as needed) Direct Care Staff (DCS #3) that was also denoted as the med-tech (Medication Technician, A staff who assists with the self-administration of medications) on site for the shift. B. On 04/29/24 at 3:27 pm during an interview with complainant for NM [redacted] they stated that on the morning of 03/11/24, the [redacted] provider met with them at the facility with R #1 and personal caregiver (a private caregiver who is compensated independently and not employed by the facility) on site to discuss changes in condition with R #1 and gave a [redacted] The facility DCS in addition to the Program Director were notified and made aware of this [redacted] and it was to be held on-site in the medication room. C. On 04/29/24 at 3:27 pm during an interview with complainant, they stated that she received a call from her personal caregiver at 4:50 am stating that R #1 was having [redacted] The complainant arrived at the facility 10-15 minutes after the call,	A 069		

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A 069	Continued From page 37 and went with personal caregiver to find unit staff to administer medications from the [redacted] They located DCS #14 by the nurse's station, asleep on the couch and woke her up to administer medication to R #1. DCS #14 was not a med-tech and was unable to administer medication. D. On 04/29/24 at 3:27 pm during an interview with the complainant, she stated that DCS #14 made a call to the on-call manager for a med tech to give R #1 medications from the [redacted] and was told that DCS #2 would be on site soon. DCS #14 left to the facility's north side to help and told the complainant that she would return. The complainant stated that a DCS from the assisted living facility down the hill from the memory care unit arrived at the unit after 6:00 am to help give medications from the [redacted] After this specific incident, the complainant stated they worked with the facility and [redacted] o get a lock box for the [redacted] for the private caregiver to distribute medications moving forward. E. On 05/08/24 at 10:01 am, during an interview, DCS #2 confirmed that DCS #3 had not been to the facility for their graveyard shift. DCS #3 was scheduled to be the shift floater staff (A floater is an extra staff that is able to work in multiple units as needed) and was also the only med tech on the schedule for the Memory Care Unit and was not replaced with another on-site med tech. DCS #2 received a phone call at 4:50 am from DCS #14 at the facility to ask for [redacted] R #1. About 5-10 minutes later, DCS #2 received another call from DCS #14 for medications from the [redacted] and said that they would be en route to the facility shortly. DCS #2 confirmed that they arrived at the facility after 6:00 am and the	A 069		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	4123	A. BUILDING: _____ B. WING _____	C 05/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONTECITO SANTA FE MEMORY CARE COMMUNITY	450 RODEO ROAD SANTA FE, NM 87505

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A 069	Continued From page 38 medications needed had been administered. F. On 4/30/24 at 2:22 pm, during an interview with the Program Director, she stated that the facility has experienced short staffing and that the goal for the MCU is to hire at least four to five (4-5) more caregivers to the current staff roster. The program manager feels that would leave the unit more adequately staffed for two-person assistance, feedings and toileting/changing residents who require extra care for those tasks. a. The Program Director stated that she recalled a meeting with [redacted] on 03/11/24 to discuss R #1 changes of condition and that [redacted] with the facility to be given PRN. b. The Program Director stated the morning of 03/12/24, she called the On-Call Manager and Nurse in addition[redacted]o see if anyone could get to the facility to administer the[redacted] c. The Program Director stated that on-call Nurse called over to the assisted living side of the facility and got a med tech to administer medications to R #1. d. The Program Director confirmed that they met with[redacted]the Complainant, and private caregiver to approve a lock box for the[redacted] to be held in R #1's room to be given by private caregiver. e. The Program Director confirmed that she creates the work schedules with the manager's approval from the Administrator. If a staff member calls off for their scheduled shift. In that case, they must first contact the on call manager on the schedule for the week, who reaches out to the Program Director and Administrator to obtain shift coverage if needed; if this cannot be covered, the on-call manager is to cover the vacant shift.	A 069		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	4123	A. BUILDING: _____ B. WING _____	C 05/08/2024

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A 069	Continued From page 39 G. On 05/06/24 at 1:00 pm during an interview with the Administrator, he confirmed that on the morning of 03/12/24, there had been a staffing shortage in the south side of the memory care unit in the capacity of a med-tech. That shortage prevented them from providing PRN medications to R #1 at their request time. He confirmed that the above findings were accurate and that the PRN medication was given by one of the med techs stationed at the assisted living side of the facility approximately an hour after the request was initially made. a. The Administrator stated that the count for staff supervisors on the shifts at the memory care unit currently are one AM supervisor, two PM supervisors and one Graveyard supervisor. b. The Administrator stated that the call-in procedure for DCS is to contact their on call manager, who is to find shift coverage with approval. if that shift is unable to be covered, the manager is expected to cover it physically.	A 069		