STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	7026	A. BUILDING: _____ B. WING _____	08/18/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASITA SENIOR LIVING LLC	5141 GEORGIA PL NE RIO RANCHO, NM 87144

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 000	Initial Comments The following deficiencies were cited during an initial survey completed on 08/18/21 for the state requirements of 7 NMAC 8.2, Regulations for Assisted Living.	A 000		
A 016	7 NMAC 8.2.16 Staff Qualifications STAFF QUALIFICATIONS: A facility shall employ staff with the following qualifications. A. Administrator, director, operator: an assisted living facility shall be supervised by a full-time administrator. Multiple facilities that are located within a forty (40) mile radius may have one full-time administrator. The administrator shall: (1) be at least twenty-one (21) years of age; (2) have a high school diploma or its equivalent; (3) comply with the requirements of the New Mexico Caregivers Criminal History Screening Act, 7.1.9 NMAC; (4) complete a state approved certification program for assisted living administrators; (5) be able to communicate with the residents in the language spoken by the majority of the residents; (6) not work while under the influence of alcohol or illegal drugs; (7) have evidence of education and experience to prove the ability to administer, direct and operate an assisted living facility; the evidence of education and experience shall be directly related to the services that are provided at the facility; (8) provide three (3) notarized letters of reference from persons unrelated to the applicant; and (9) comply with the pre-employment requirements pursuant to the Employee Abuse Registry, 7.1.12 NMAC. B. Direct care staff: (1) shall be at least eighteen (18) years of age; (2) shall have adequate education, relevant	A 016		

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A 016	Continued From page 1 training, or experience to provide for the needs of the residents; (3) shall comply with the pre-employment requirements pursuant to the Employee Abuse Registry, 7.1.12 NMAC; and (4) shall comply with the current requirements of reporting and investigating incidents pursuant to Incident Reporting, Intake Processing and Training Requirements, 7.1.13 NMAC; (5) if a facility provides transportation for residents, the employees of the facility who drive vehicles and transport residents shall have copies of the following documents on file at the facility: (a) a valid New Mexico driver ' s license with the appropriate classification for the vehicle that is used to transport residents; (b) documentation of training in transportation safety for the elderly and disabled, including safe vehicle operation; (c) proof of insurance; and (d) documentation of a clean driving record; (6) any person who provides direct care who is not employed by an agency that is covered by the requirements of the Caregivers Criminal History Screening Requirements, 7.1.9 NMAC, shall provide current (within the last 6 months) proof of the caregivers criminal history screening to the facility; the facility shall maintain and have proof of such screening readily available; and (7) employers shall comply with the requirements of the Caregivers Criminal History Screening Requirements, 7.1.9 NMAC. [7.8.2.16 NMAC - Rp, 7.8.2.16 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by:	A 016		

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A 016	Continued From page 2 7.8.2.16. A (4) Based on record review and interview, the facility failed to ensure that the Administrator had taken and received a certificate of completion from a state approved training course for Administrators operating an Assisted Living Facility. This deficient practice has could likely to affect the safety and welfare of the 4 (R #s 1 through 4) residents identified on the census provided by the Administrator on 08/17/21, if residents are being taken care of by an unqualified/uncertified Administrator. The findings are: A. Record review of the Administrator's certificate of completion dated 12/16/18 revealed that the certificate received by the Administrator was not from a state approved training course for Assisted Living Administrators. B. On 08/18/21 at 3:30 pm, during an interview with the Administrator, she confirmed she had not completed or received at certificate of completion from a state approved Administrators training course. She stated she was unaware that the certification course she took was not a state approved course.	A 016	After confirming with NMDOH that the Administrators MSN degree in Health System Administration as well as National Assisted Living Training certificate from 12/16/2018 was not acceptable, the Administrator on 9/15/2021 registered for a State Approved Administrator training course. ON 10/4/21 the Administrator completed the Administrator training course's received the certifate.	10/4/21
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	A 017		

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A 017	Continued From page 3 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; (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 C (1-12)	A 017		

Division of Health Improvement

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A 017	Continued From page 4 Based on record review and interview the facility failed to ensure that there was documentation maintained onsite and available for review that the Direct Care Staff (DCS) completed the following required trainings: 1. 16 hours of supervised training prior to providing unsupervised care to residents. 2. 12 hours of orientation training required by regulation. 3. Maintained the DCS training documentation onsite and available for review in the Licensing Authority. This deficient practice could likely result in the 4 (R #1 through 4) residents listed on the census provided by the Administrator on 08/17/21, to be at risk of harm or injury if: 1. The DCS have not received the required trainings on the proper methods of providing care and services. 2. If there is no documentation onsite and available for review to confirm that the DCS have completed the trainings, then the residents are at risk of being provided care and services by untrained DCS. The findings are: A. Record request of Staff Training files for DCS #s 1 through 4 revealed no documentation was onsite and available for review by the Licensing Authority. B. On 08/17/21 at 3:30 pm, during an interview, the Administrator confirmed that she was not able to locate the signed employee personnel files for DCS #s 1 through 4 that contained documentation of completion of the 16 hours of supervised training prior to working independently	A 017	8/23/21 Administrator located documents that provided 16 hours of Supervised training and will be kept in the home (facility). Monthly audits by Manager [redacted] will ensure all staff is maintaining/completing all necessary training.	8/23/21

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A 017	Continued From page 5 with residents or of 12 hours of annual training.	A 017		
A 020	7 NMAC 8.2.20 Admissions and Discharge ADMISSIONS AND DISCHARGE: The facility shall complete an admission agreement for each resident. The administrator of the facility or a designee responsible for admission decisions shall meet with the resident or the resident ' s surrogate decision maker prior to admission. No resident shall be admitted who is below the age of eighteen (18) or for whom the facility is unable to provide appropriate care. A. Admission agreement. The admission agreement shall include the following information: (1) the parties to the agreement; (2) the program narrative; (3) the facility's rules; (4) the cost of services and the method of payment; (5) the refund provision in case of death, transfer, voluntary or involuntary discharge; (6) information to formulate advance directives; (7) a written description of the legal rights of the residents translated into another language, if necessary; (8) the facility's staffing ratio; (9) written authorization for staff to assist with medications; (10) notification of rights and responsibilities pursuant to the Incident Reporting Intake, Processing and Training Requirements, 7.1.13 NMAC; (11) the facility ' s bed hold policy; and (12) the admission agreement may be terminated if an appropriate placement is found for the resident, under the following circumstances: (a) there shall be a fifteen (15) day written notice of termination given to the resident or his or her	A 020		

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A 020	Continued From page 6 surrogate decision maker, unless the resident requests the termination; (b) the resident has failed to pay for a stay at the facility as defined in the admission agreement; (c) the facility ceases to operate or is no longer able to provide services to the resident; (d) the resident ' s health has improved sufficiently and therefore no longer requires the services of the facility; (e) termination without prior notice is permitted in emergency situations for the following reasons: (i) the transfer or discharge is necessary for the resident's safety and welfare; (ii) the resident's needs cannot safely be met in the facility; or (iii) the safety and health of other residents and staff in the facility are endangered; (13) the facility shall provide a thirty (30) day written notice to residents regarding any changes in the cost or the material services provided; a new or amended admission agreement must be executed whenever services, costs or other material terms are changed; and (14) facilities representing their services as " specialized " must disclose evidence of staff specialty training to prospective residents. B. Restrictions in admission. The facility shall not admit or retain individuals that require twenty-four (24) hour continuous nursing care, refer to Subsection U of 7.8.2.7 NMAC Definitions. This rule does not apply to hospice residents who have elected to receive the hospice benefit. Conditions or circumstances that usually require continuous nursing care may include but are not limited to the following: (1) ventilator dependency; (2) pressure sores and decubitus ulcers (stage III or IV); (3) intravenous therapy or injections;	A 020		

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A 020	Continued From page 7 (4) any condition requiring either physical or chemical restraints; (5) nasogastric tubes; (6) tracheostomy care; (7) residents that present an imminent physical threat or danger to self or others; (8) residents whose psychological or physical condition has declined and placement in the current facility is no longer appropriate as determined by the PCP; (9) residents with a diagnosis that requires isolation techniques; (10) residents that require the use of a Hoyer lift; and (11) ostomy (unless resident is able to provide self care). C. Exceptions to admission, readmission and retention. If a resident requires a greater degree of care than the facility would normally provide or is permitted to provide and the resident wishes to be re-admitted or remain in the facility and the facility wishes to re-admit or retain the resident. The facility shall comply with the following requirements. (1) Convene a team, comprised of: (a) the facility administrator and a facility health care professional if desired; (b) the resident or resident ' s surrogate decision maker; and (c) the hospice or home health clinician. (2) The team shall jointly determine if the resident should be admitted, readmitted or allowed to remain in the facility. Team approval shall be in writing, signed and dated by all team members and the approval shall be maintained in the resident's record and shall: (a) be based upon an individual service plan (ISP) which identifies the resident's specific needs and addresses the manner that such	A 020		

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A 020	Continued From page 8 needs will be met; (b) ensure that if the facility is licensed for more than eight (8) residents and does not have complete fire sprinkler coverage, the facility shall maintain an evacuation rating score of prompt as determined by the fire safety equivalency system (FSES); (c) evaluate and outline how meeting the specific needs of the resident will impact the staff and the other residents; and (d) include an independent advocate such as a certified ombudsman if requested by the resident, the family or the facility. (3) The team recommendation shall be maintained on site in the resident ' s file. (4) When a resident is discharged, the facility shall record where the resident was discharged to and what medications were released with the resident. D. Coordination of care. (1) Assisted living facilities shall have evidence of care coordination on an ISP for all services that are provided in the facility by an outside health care provider, such as hospice or home health providers. (2) Residents shall be given a list of providers, including hospice and home health if applicable, and have the right to choose their provider. If applicable, the referring party shall disclose any ownership interest in a recommended or listed provider. [7.8.2.20 NMAC - Rp, 7.8.2.19 NMAC & 7.8.2.20 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.20 A (5)	A 020		

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A 020	Continued From page 9 Senate Bill (SB) 0335 - 2013 AN ACT RELATING TO HEALTH CARE; REQUIRING CONTRACTS FOR ASSISTED LIVING FACILITIES TO CONTAIN A REFUND POLICY UPON TERMINATION OF A CONTRACT DUE TO THE DEATH OF THE RESIDENT; PROVIDING FOR STORAGE OF A RESIDENT'S BELONGINGS; DECLARING AN EMERGENCY. BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF NEW MEXICO: SECTION 1. A new section of the Public Health Act is enacted to read: "ASSISTED LIVING FACILITIES CONTRACTS--LIMIT ON CHARGES AFTER RESIDENT DEATH.-- A. The contract for each resident of an assisted living facility shall include a refund policy to be implemented at the time of a resident's death. The refund policy shall provide that the resident's estate or responsible party is entitled to a prorated refund based on the calculated daily rate for any unused portion of payment beyond the termination date after all charges have been paid to the licensee. For the purpose of this section, the termination date shall be the date the unit is vacated by the resident due to the resident's death and cleared of all personal belongings. B. If a resident's belongings are not removed within one week of the resident's death and the amount of belongings does not preclude renting the unit, the facility may clear the unit and charge the resident's estate for moving and storing the items at a rate equal to the actual cost to the facility, not to exceed ten percent of the regular rate for the unit; provided that the responsible party for the resident is given notice at least one week before the resident's	A 020	completed	8/23/21

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A 020	Continued From page 10 belongings are removed. If the resident's belongings are not claimed within forty-five days after notification, the facility may dispose of them. C. For the purposes of this section, "assisted living facility" means a facility required to be licensed as an assisted living facility for adults by the department of health." SECTION 2. EMERGENCY.--It is necessary for the public peace, health and safety that this act take effect immediately. Based on record review and interview, the facility failed to ensure for 4 (R #s 1 through 4) of 4 (R #s 1 through 4) residents whose Admission/Discharge Agreements were reviewed for compliance included a refund upon death policy that was in compliance with Senate Bill (SB) 0335 - 2013 and 7 NMAC 8.2.20. This deficient practice could likely result in the residents estate/legal representative party suffering financial hardship by not receiving the refund that is due upon the resident's death or incurring unknown charges for storage of their belongings. The findings are: Findings related to Admission/Discharge Agreements A. Record Review of R #s 1 through 4 Admission/Discharge Agreements revealed that they did not include a refund upon death policy in compliance with with Senate Bill (SB) 0335 - 2013 and 7 NMAC 8.2.20. B. On 08/18/21 at 3:30 pm, during an interview with the Administrator, she confirmed that R #s 1	A 020	8/23/21 Added refund policy on 8/23/21 to the resident contracts outlining the refund policy for Casita Senior Living in case of death within the first 30 days. Also included is the process for removing residents belongings within 45 days of death. All admission agreements are now in compliance with Senate bill 0335-2013 and 7 NMAC 8.2.20. and will continue to be in compliance moving forward with new residents.	

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A 020	Continued From page 11 through 4 Admission/Discharge Agreements did not include a the refund upon death policy that is in compliance with SB 0335- 2013 and 7 NMAC 8.2.20.	A 020		
A 021	7 NMAC 8.2.21 Resident Records RESIDENT RECORDS: A. Record contents. A record for each resident shall be maintained in accordance with the specific requirements of this section. Entries in each resident's record shall be legible, dated and authenticated by the signature of the person making the entry. Resident records shall be readily available on site and organized utilizing a table of contents. Each resident record shall include: (1) the admission agreement records, as set forth in 7.8.2.20 NMAC; (2) the resident evaluation form, that is to be completed within fifteen (15) days prior to admission and updated at a minimum of every six (6) months; (3) the current ISP, that is to be completed within ten (10) calendar days of admission and updated at a minimum of every six (6) months; (4) the physical examination report; the physical examination report shall have been completed within the past six (6) months, by a primary care physician, a nurse practitioner or a physician ' s assistant and shall be on file in the resident ' s record within ten (10) days of admission; (5) personal and demographic information for the resident, to include: (a) current names, addresses, relationship and phone numbers of family members, or surrogate decision makers updated as necessary; (b) resident's name; (c) age;	A 021		

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A 021	Continued From page 12 (d) recent photograph; (e) marital status; (f) date of birth; (g) sex; (h) address prior to admission; (i) religion (optional); (j) personal physician; (k) dentist; (l) social history; (m) surrogate decision maker or other emergency contact person; (n) language spoken and understood; (o) legal documentation relevant to commitment or guardianship status; (p) current medications list; and (q) required diet; (6) unless included in the admission agreement, a separate written agreement between the facility and the resident relating to the resident's funds, in accordance with the facility's policy and procedures; (7) entries by direct care staff, appropriate health care professionals and others authorized to care for the resident; entries shall be dated and signed by the person making the entry and shall include significant information related to the ISP; (8) entries that provide a written account of all accidents, injuries, illnesses, medical and dental appointments, any problems or improvements observed in the resident, any condition that would indicate a need for alternative placement or medical attention and entries reflecting appropriate follow-up; the maintenance of such written documentation in the resident record may be by copy of an incident or accident report, if the original incident or accident report is maintained elsewhere by the facility; (9) the medication assistance record (MAR); the MAR is the document that details the resident's	A 021		

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A 021	Continued From page 13 medication; the MAR shall include all of the information pursuant to Subsection G of 7.8.2.35 NMAC of this rule; (10) progress notes completed by any contract agency (e.g., hospice, home health); the progress notes shall include the date, time and type of health services provided; (11) copies of all completed and signed transfer forms from the accepting facility when a resident is transferred to a hospital or another health care facility and when the resident is transferred back to the facility; and (12) upon the death or transfer of a resident, documentation of the disposition of the resident's personal effects and money or valuables that are deposited with the assisted living facility. B. Resident records maintenance. (1) Current resident records shall be maintained on-site and stored in an organized, accessible and permanent manner. (2) The facility shall establish a policy to maintain and ensure the confidentiality of resident records, including the authorized release of information from the resident records. (3) Non-current resident records shall be maintained by the facility against loss, destruction and unauthorized use for a period of not less than five (5) years from the date of discharge and readily available within twenty-four (24) hours of request. (4) There shall be a policy and procedure in place for record retention in the event of facility closure. (5) Failure to follow facility policies is grounds for sanctions. [7.8.2.21 NMAC - Rp, 7.8.2.22 NMAC, 01/15/2010]	A 021		

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	7026	A. BUILDING: _____ B. WING _____	08/18/2021

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A 021	Continued From page 14 This REQUIREMENT is not met as evidenced by: 7.8.2.21 A (5) (d) Based on record review and interview, the facility failed to ensure for 4 (R #s 1 through 4) of 4 (R #s 1 through 4) residents whose records were reviewed for compliance were organized utilizing a table of contents and included a recent photograph. This deficient practice could likely result in the residents being at risk of injury or harm, if the Direct Care Staff (DCS) who provide care and services attended to the wrong resident because there was no identifying picture in the resident's chart or could not quickly find relative information during an emergency. The findings are: A. Record review of R #1's resident chart revealed that the documentation was not organized utilizing a table of contents and did not include a photograph of this resident. B. Record review of R #2's resident chart revealed that the documentation was not organized utilizing a table of contents and did not include a photograph of this resident. C. Record review of R #3's resident chart revealed that the documentation was not organized utilizing a table of contents and did not include a photograph of this resident. D. Record review of R #4's resident chart revealed that the documentation was not organized utilizing a table of contents and did not include a photograph of this resident. E. On 08/19/21 at 3:30 pm, during the exit	A 021		

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A 021	Continued From page 15 Interview with the Administrator, she confirmed that R #s 1 through 4 resident charts were not organized utilizing a table of contents and did not include a current photo of the resident.	A 021	On 8/23/21 Resident files were organized with a table of contents following the order of State Regulations A photo was added for every resident's placed in their files. The administrator will continue to follow this order & filing system with all future residents. The manager [redacted] will audit files monthly to ensure facility is in compliance with State Regulations at all times.	8/23/21
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; (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	A 026		

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A 026	Continued From page 16 require with activities of daily living and with medications; (10) a crisis prevention/intervention plan when indicated by diagnosis or behavior; and (11) current orders for all medications, including those authorized for PRN usage. [7.8.2.26 NMAC - Rp, 7.8.2.26 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.26 B (7) Based on record review and interview, the facility failed to ensure for 4 (R #s 1 through 4) of 4 (R #s 1 through 4) residents whose Individual Service Plans (ISPs) were reviewed for compliance included goals and expected outcomes. This deficient practice could likely cause the residents to not achieve or maintain their highest level of mental and physical function if the Direct Care Staff (DCS) are not aware of what the resident's individual goals and expected outcomes are to provide the care and services needed. The findings are: A. Record review of R #1's ISP dated 05/01/21 revealed there were no goals or expected outcomes noted on the ISP. B. Record review of R #2's ISP dated 05/17/21 revealed there were no goals or expected outcomes noted on the ISP.	A 026	ON 8/23/21 Administrator went back to ISP Plans for 5-1-21 and 5-17-21 and added goals & outcomes for every resident for R#1's & R#2's	8/23/21

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A 026	Continued From page 17 C. Record review of R #3's ISP dated 05/16/21 revealed there were no goals or expected outcomes noted on the ISP. D. Record review of R #4's ISP dated 05/22/21 revealed there were no goals or expected outcomes noted on the ISP. E. On 08/18/21 at 3:30 pm, during an interview with the Administrator, she confirmed that the ISPs for R #s 1 through 4 did not include goals or expected outcomes noted on the ISP's.	A 026	Corrected R#3's report dated 5/16/21 to include goals & expected outcomes corrected R#4's report dated 5/22/21 to reflect goals & expected outcomes.	8/23/21 8/23/21
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	A 034	Administrator will monitor ISP's & audit monthly to ensure facility is in compliance and staff is following each residents ISP per there needs properly. Administrator to follow up with residents staff to ensure residents needs are met.	

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A 034	Continued From page 18 provided by the facility for medications. The refrigerator temperature shall be kept in compliance with the state board of pharmacy requirements for medications. (4) All medications, including non-prescription medications, shall be stored in separate compartments for each resident and all medications shall be labeled with the resident's name. (5) A resident may be permitted to keep his or her own medication in a locked compartment in his or her room for self-administration, if the physician's order deems it appropriate. (6) The facility shall not require the residents to purchase medications from any particular pharmacy. (7) Medical gases (oxygen) and equipment used for the administration of inhalation therapy and for resuscitative purposes shall comply with the national fire protection association (NFPA) 99. (8) A proof of use record shall be maintained separately for each schedule II through IV drug (controlled substances). The proof of use sheet shall document: (a) the type and strength of the schedule II through IV drugs; (b) the date and time staff assisted with self-administration; (c) the resident ' s name; (d) the prescriber ' s name; (e) the dose; (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	A 034		

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A 034	Continued From page 19 upon the next quarterly visit by the consulting pharmacist in accordance with 16.19.11.10 NMAC. (10) The record of medication destruction shall be signed by the administrator or designee and the pharmacist and shall be kept on file at the facility. B. Consulting pharmacist. The facility shall maintain records demonstrating that the consulting pharmacist provides the following oversight and guidance. (1) Reviews the medication regimen as needed, but at least quarterly/every three (3) months, to determine that all medications and records are accurate and current. All irregularities shall be reported to the administrator of the facility and these irregularities shall be resolved by the administrator within seventy-two (72) hours. (2) A system of records of receipt and disposition of all drugs in sufficient detail to enable an accurate reconciliation. (3) Consultation shall be provided on all aspects of pharmacy services in the facility, including reference information regarding side effects and, when needed, physician consultation in cases involving the use of psychotropic medications. (4) The consulting pharmacist will be responsible for assuring that the facility meets all requirements for storage, labeling, destruction and documentation of medications as required by the state board of pharmacy, 16.19.11.10 NMAC and 7.8.2 NMAC. [7.8.2.34 NMAC - Rp, 7.8.2.35 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.34 A (7)	A 034		

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A 034	Continued From page 20 Reference NFPA 99 (Healthcare Facilities Code) 2012 Edition NFPA 99. 11.3 Cylinder and Container Storage Requirements. 11.3.1* Storage for nonflammable gases equal to or greater than 85 m3 (3000 ft3) at STP shall comply with 5.1.3.3.2 and 5.1.3.3.3. 11.3.2* Storage for nonflammable gases greater than 8.5 m3 (300 ft3), but less than 85 m3 (3000 ft3), at STP shall comply with the requirements in 11.3.2.1 through 11.3.2.3. 11.3.2.1 Storage locations shall be outdoors in an enclosure or within an enclosed interior space of noncombustible or limited combustible construction, with doors (or gates outdoors) that can be secured against unauthorized entry. 11.3.2.2 Oxidizing gases, such as oxygen and nitrous oxide, shall not be stored with any flammable gas, liquid, or vapor. 11.3.2.3 Oxidizing gases such as oxygen and nitrous oxide shall be separated from combustibles or materials by one of the following: (1) Minimum distance of 6.1 m (20 ft) (2) Minimum distance of 1.5 m (5 ft) if the entire storage location is protected by an automatic sprinkler system designed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems (3) Enclosed cabinet of noncombustible construction having	A 034	On 8/19/21 Administrator called Hospice to order storage containers for cylinders while the facility is waiting storages to arrive. On 9/23/21 storages for cylinders arrived and were mounted, secured, and labeled to follow State regulations. Manager [redacted] will audit monthly that weekly checks by staff are completed to ensure cylinders stored in designated area properly at all times.	8/23/21 9/23/21

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A 034	Continued From page 21 a minimum fire protection rating of 1?2 hour 11.3.2.4 Gas cylinder and cryogenic liquid container storage shall comply with 5.1.3.5.12. 11.3.2.5 Cylinder and container storage locations shall comply with 5.1.3.3.1.7 with respect to temperature limitations. 11.3.2.6 Cylinder or container restraints shall comply with 11.6.2.3. 11.3.2.7 Smoking, open flames, electric heating elements, and other sources of ignition shall be prohibited within storage locations and within 6.1 m (20 ft) of outside storage locations. 11.3.2.8 Cylinder valve protection caps shall comply with 11.6.2.3. 11.3.2.9 Gas cylinder and liquefied gas container storage shall comply with 5.1.3.5.12. 11.3.3 Storage for nonflammable gases with a total volume equal to or less than 8.5 m3 (300 ft3) shall comply with the requirements in 11.3.3.1 and 11.3.3.2. 11.3.3.1 Individual cylinder storage associated with patient care areas, not to exceed 2100 m2 (22,500 ft2) of floor area, shall not be required to be stored in enclosures. 11.3.3.2 Precautions in handling cylinders specified in 11.3.3.1 shall be in accordance with 11.6.2. 11.3.3.3 When small-size (A, B, D, or E) cylinders are in use, they shall be attached to a cylinder stand or to medical equipment	A 034		

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A 034	Continued From page 22 designed to receive and hold compressed gas cylinders. 11.3.3.4 Individual small-size (A, B, D, or E) cylinders available for immediate use in patient care areas shall not be considered to be in storage. 11.3.3.5 Cylinders shall not be chained to portable or movable apparatus such as beds and oxygen tents. 11.3.4 Signs. 11.3.4.1 A precautionary sign, readable from a distance of 1.5 m (5 ft), shall be displayed on each door or gate of the storage room or enclosure. 11.3.4.2 The sign shall include the following wording as a minimum: CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING 2012 Edition Based on observation and interview, the facility failed to ensure that oxygen cylinder tanks were stored securely and protected from accidental damage or dislocation. This deficient practice could likely result in the 4 (R #s 1 through 4) residents identified on the resident census list provided by the Administrator on 08/17/21, to be at risk of harm, injury, or death if the oxygen cylinder tanks were to fall over damaging the valve, causing them to depressurize during a fire, the oxygen feeds the fire, causing it to spread faster and/or the cylinder tanks act like missiles and hit a resident/staff/rescuer during a fire. The findings are:	A 034		

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A 034	Continued From page 23 A. On 08/17/21 at 1:17 pm, during an observation of the facility garage, 4 large oxygen tanks (unsecured) were observed on the ground next to the fire suppression tank. B. On 08/18/21 at 3:30 pm, during an interview with the Administrator, she confirmed that the unsecured oxygen tanks had been left in the garage.	A 034		
A 035	7 NMAC 8.2.35 Medication MEDICATIONS: Administration of medications or staff assistance with self-administration of medications shall be in accordance with state and federal laws. No medications, including over-the-counter medications, PRN (when needed) medications, or treatment shall be started, changed or discontinued by the facility without an order from the physician, physician assistant or nurse practitioner and with entry into the resident's record. A. State board of nursing licensed or certified health care professionals are responsible for the administration of medications. Administration may only be performed by these individuals. B. Facility staff may assist a resident with the self-administration of medications if written consent by the resident is given to the administrator of the facility or the administrator ' s designee. If the resident is incapable of giving consent, the surrogate decision maker named in accordance with New Mexico law may give written consent for assistance with self-administration of medications. All staff that assist with self-administration of medications shall have successfully completed a state approved assistance with self-administration of	A 035		

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A 035	Continued From page 24 medication training program or be licensed or certified by the state board of nursing. C. PRN (pro re nada) medication. (1) Physician or physician extender ' s orders for PRN medications shall clearly indicate the circumstances in which they are to be used, the number of doses that may be given in a 24-hour period and indicate under what circumstances the primary care practitioner (PCP) is to be notified. (2) The utilization of PRN medications shall be reviewed routinely. Frequent or escalating use of PRN medications shall be reported to the PCP. D. Only a licensed nurse (RN or LPN) shall administer any medications or conduct any invasive procedures provided by the following routes: intravenous (IV), subcutaneous (SQ), intramuscular (IM), vaginal or rectal. Only a licensed nurse shall administer non-premixed nebulizer treatments. E. The facility shall have medication reference material that contains information relating to drug interactions and side effects on the premises. Staff that assist in the self-administration of medications shall know interactions or possible side effects that might occur. F. Medications prescribed for one resident shall not be used for another resident. G. Medication assistance record (MAR). For residents who are not independent and require assistance with self administration, the facility shall have a MAR that documents the details of the residents' medication, including PRN and over-the-counter medication that is assisted with self-administration by qualified staff or administered to the resident by licensed or certified staff. The information in the MAR shall include: (1) the resident's name; (2) any known allergies to medication that the	A 035		

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A 035	Continued From page 25 resident has; (3) the name of the resident's PCP or the prescriber of the medication; (4) the diagnosis or reason for the medication; (5) the name of the medication, including the drug product brand name and the generic name; (6) notation if the medication is a schedule II-IV drug; (7) the dosage of the medication; (8) the strength of the medication; (9) the frequency or how often the medication is to be taken or given; (10) the route of delivery for the medication (mouth, eye, ear, other); (11) the method of delivery for the medication (pills, drops, IM injection, other); (12) the date that the medication was started or discontinued; (13) any change in the medication order; (14) pre-medication information (i.e., pulse, respiration, blood pressure, blood sugar) as required by the medication order; (15) the date and time that the medication is self-administered, administered with assistance or is administered; (16) the initials and signature of the person assisting with or administering the medication; (17) the desired results obtained from or problems encountered with the medication (pain relieved, allergic reaction, etc.); (18) any refused dose of medication; (19) any missed dose of medication; and (20) any medication error. H. No medication shall be stopped or started without specific orders from the primary care physician. I. If a resident refuses to take a prescribed medication, it shall be documented and the facility shall report it to the prescriber.	A 035		

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A 035	Continued From page 26 J. A suspected adverse reaction to a medication shall be documented on the MAR and reported immediately to the PCP and the resident's surrogate decision maker. If applicable, emergency medical treatment shall be arranged. Documentation of the event shall be kept in the resident's record. K. Prescription medication, other than blister packs and unit dose containers, shall be kept in the original container with a pharmacy label that includes the following: (1) the resident's name; (2) the name of the medication; (3) the date that the prescription was issued; (4) the prescribed dosage and the instructions for administration of the medication; and (5) the name and title of the prescriber. L. Any medication that is removed from the pharmacy container or blister pack shall be given immediately and documented by the staff that assisted with the medication delivery. M. The facility shall report all medication errors to the physician, documentation of medication errors and the prescriber's response shall be kept in the resident's record. N. The facility shall develop and follow a written policy for unused, outdated, or recalled medications kept in the facility in accordance with 16.19.11.10 NMAC (AS AMENDED). [7.8.2.35 NMAC - Rp, 7.8.2.35 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.35 G (5) Based on record review, observation, and	A 035		

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	7026	A. BUILDING: _____ B. WING _____	08/18/2021

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A 035	Continued From page 27 interview the facility failed to ensure for 4 (R #s 1 through 4) of 4 (R #s 1 through 4) residents whose Medication Administration Records (MARs) were reviewed for compliance, were accurate and contained both generic and brand names. This deficient practice could likely result in the residents being at risk of harm, illness, or death if medication errors occurred because the DCS are not familiar with the names of the medications, both the brand and generic names are not listed on the MARs, and residents are given the wrong medications. The findings are: A. Record Review of R #1's MARs dated 08/01/21 through 08/17/21 revealed that the following medications did not include both the brand/generic names: [redacted]	A 035		

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A 035	Continued From page 28 [redacted] C. Record Review of R #3's MAR dated 08/01/21 through 08/17/21 revealed that the following medications did not include both the brand/generic names: [redacted]	A 035		

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A 035	Continued From page 29	A 035		

[redacted]

D. Record Review of R #4's MAR dated 08/01/21 through 08/17/21 revealed that the following medications did not include both the brand/generic names:

[redacted]

E. On 08/18/21 at 3:30 pm, during the exit interview, the Administrator and Manager confirmed that DCS #s 1 through 4 MARs did not

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A 035	Continued From page 30 include both the brand/generic names of the medications listed above.	A 035	On 8/24/21 our Pharmacist came to the facility and together with the Administrator completed an audit of all medications and corrected the MAR to reflect the Brand Name & Generic Name of all medications for residents #1-4. Moving forward the Administrator will ensure that Both Brand & Generic name medications will be inputed to the MAR on every medication, for every resident. The Pharmacist & Administrator will continue to Audit medications quarterly to ensure all medications are entered appropriately and the facility is follow all State Regulations appropriately.	8/24/21
A 038	7 NMAC 8.2.38 Housekeeping Services HOUSEKEEPING SERVICES. The facility shall maintain the interior and exterior of the facility in a safe, clean, orderly and attractive manner. The facility shall be free from offensive odors, safety hazards, insects and rodents and accumulations of dirt, rubbish and dust. A. All common living areas and all bathrooms shall be cleaned as often as necessary to maintain a clean and sanitary environment. B. Combustibles such as cleaning rags or flammable substances shall be stored in closed metal containers in approved areas that provide adequate ventilation. Combustibles shall be stored away from the food preparation areas and away from the resident rooms. C. Poisonous or flammable substances shall not be stored in residential areas, food preparation areas or food storage areas. If hazardous chemicals are stored on the property, material safety data sheets shall be maintained and stored in the same area as the chemicals, pursuant to state environment department requirements, 11.5.2.9 NMAC. [7.8.2.38 NMAC - Rp, 7.8.2.39 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.38 (C) Based on observation and interview, the facility failed to ensure that cleaning supplies and hazardous chemicals were stored in secure areas	A 038		

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A 038	Continued From page 31 and were not accessible to the residents. This deficient practice could likely result in the 4 (R #s 1 through 4) residents listed on the census list provided by the Administrator on 08/17/21, being at risk of harm, illness, or injury if the residents were to spill or ingest the hazardous chemicals. The findings are: A. On 08/17/21 at 12:51 pm, during an observation of the utility room, the following chemicals were observed in an unlocked cabinet and accessible to residents: 1. One 24 ounce bottle of furniture and counter top cleaner 2. One 20 ounce can of bug spray B. On 08/17/21 at 12:52 pm, during an observation of the kitchen, the following cleaning chemicals were observed in an unlocked cabinet under the sink and accessible to residents: 1. One 23 ounce can of glass cleaner 2. One 64 ounce bottle of distilled white vinegar 3. One 80 ounce bottle of hand soap 4. One 32 ounce spray bottle of air deodorizer 5. One 32 ounce spray bottle of bleach solution 6. One gallon of disinfectant solution 7. One 125 ounce bottle of dishwasher detergent 8. One 90 ounce bottle of dishsoap 9. One 75 ounce bottle of concentrated dish soap 10. One 32 ounce bottle of all purpose cleaner 11. One 636 milliliter (ml) bottle of hand soap 12. One 19 ounce can of disinfectant spray C. On 08/17/21 at 1:10 pm, during an	A 038	8/18/21 All cleaning solvents in the home were moved to the Laundry room cabinets. The laundry room has a door which locks and will remain locked @ all times. All employees were trained on keeping all chemicals, cleaning supplies, bug sprays, glass cleaner, vinegar solutions are to be kept only in the laundry room and locked away from	8/18/21

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A 038	Continued From page 32 observation of the South side bathroom near resident rooms #s 1 through 5, the following cleaning chemicals were observed in an unlocked cabinet under the sink: 1. One 32 ounce spray bottle of air deodorizer 2. One 36 ounce bottle of bleach cleanser with bleach 3. One 25 ounce can of bathroom cleaner 4. One 23 ounce can of glass cleaner	A 038	patients. Items #1.-4. all moved to Laundry and kept under locked door at all times	8/18/21
	D. On 08/17/21 at 1:20 pm, during an observation of the facility laundry room, the following chemicals were observed in unlocked cabinets: 1. One gallon of all-purpose cleaning solution 2. Three 121 ounce bottles of bleach 3. One gallon of hand sanitizer 4. One gallon of air deodorizer 5. One gallon of multi-surface cleaner 6. Three 160 ounce bottles of fabric softener 7. One 23 ounce can of glass cleaner 8. One 1.99 gallon of advanced laundry detergent 9. One 19 ounce can of disinfectant spray 10. One 32 ounce spray bottle of multipurpose cleaner		Items #1-10 all moved to Laundry and kept under locked door @ all times	8-18-21
	E. On 08/17/21 at 1:27 pm, during an observation of the north side bathroom near resident room #8, the following cleaning chemicals were observed in an unlocked cabinet under the bathroom sink: 1. One 23 ounce can of glass cleaner 2. One 32 ounce spray bottle of multipurpose cleaner 3. One 32 ounce spray bottle of disinfectant 4. One 1.5 liter (L) bottle of mouthwash 5. One 24 ounce bottle of toilet bowl cleaner with bleach		Items #1-5 all moved to Laundry and kept under locked door @ all times	8-18-21

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A 038	Continued From page 33 F. On 08/17/21 at 1:35 pm, during an interview with the Administrator, she confirmed that the above listed cleaning supplies and chemicals were not being stored securely and were accessible to residents.	A 038	Administrator moved all chemicals out of the kitchen and out of all bathrooms. Gave proper training to staff on importance of maintaining chemicals under locked cabinets. All staff was trained & educated on keeping chemicals in locked designated cabinets when not in use. Manager [redacted] will ensure chemicals are stored properly when not in use. This task has also been added to daily duties to ensure proper storage at all times.	8/18/21
A 049	7 NMAC 8.2.49 Doors DOORS: A. No door in any means of egress shall be locked against egress when the building is occupied. (1) Exit doors may be provided with a night latch, dead bolt, or security chain, provided these devices are operable from the inside, by any occupant, without the use of a key, tool, or any special knowledge and are mounted at a height not to exceed forty-eight (48) inches above the finished floor. (2) If locks are not readily operable by all occupants within the building, the locks must: 1) unlock upon activation of the fire detection or sprinkler system and 2) unlock upon loss of power in the facility. Prior to installing such locking devices, the facility shall have written approval from the building, fire and licensing authorities having jurisdiction. B. All exit doors shall have a minimum width of thirty-six (36) inches. (1) Facilities with a capacity of ten (10) or more residents shall have exit doors leading to the outside of the facility that open outward. (2) Facilities with a capacity of fifty (50) or more residents must provide panic hardware at the exit doors. (3) No door or path of travel to a means of egress shall be less than twenty-eight (28) inches wide. C. All resident sleeping room doors must be at	A 049		

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A 049	Continued From page 34 least one and three-quarters (1 3/4) inch solid core construction. D. Bathroom doors may be twenty-four (24) inches wide. Facilities with four (4) or more residents shall have at least one bathroom for every eight (8) residents with a door clearance of thirty-six (36) inches for access by persons with disabilities. E. Locks on doors to toilet rooms and bathrooms shall be capable of release from the outside. F. All doors shall readily open from the inside. G. Doors shall be provided for all resident sleeping rooms, all restrooms and all bathrooms. [7.8.2.49 NMAC - Rp, 7.8.2.50 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.49 F Based on observation and interview, the facility failed to ensure that the resident bedroom and bathroom doors could be readily opened (1-motion) from the inside when locked. The deficient practice could likely result in the current 4 (R #s 1 through 4) and future residents listed on the resident census, provided by the Administrator on 08/17/21 to be at risk of injury, harm, or death if their bedroom or bathroom doors are locked and they are unable to evacuate in the event of a fire, loss of power, or other emergency that requires evacuation occurs. The findings are: A. On 08/17/21 at 1:05 pm, during observation of resident bedroom #s 1 through 9, the doors were observed to have a lock that would require 2 motions to exit the bedroom.	A 049	ON 8/23/21 our handyman 8/23/21 came to the ALF and removed locks on bedrooms #1-9 to ensure all bedroom doors & bathrooms will always open with one motion. Should knobs need to be replaced in the future they will be replaced with one-motion door knobs.	

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A 049	Continued From page 35 B. On 08/17/21 at 1:10 pm, during an observation of the 2 (two) resident bathrooms, the doors were observed to have locks on them that would require 2 motions to exit the bathroom. C. On 08/18/21 at 3:30 pm, during an interview with the Administrator, she confirmed the observation that the doors in all resident bedrooms and bathrooms would not readily open with 1 motion.	A 049		
A 065	7 NMAC 8.2.65 Fire Drills FIRE DRILLS: All facilities shall conduct monthly fire drills which are to be documented. A. There shall be at least one (1) documented fire drill per month and at a minimum, one documented fire drill each eight (8) hours (day, evening, night) per quarter that employs the use of the fire alarm system or the detector system in the facility. B. A record of the monthly fire drills shall be maintained on file in the facility and readily available. Fire drill records shall show: (1) the date of the drill; (2) the time of the drill; (3) the number of staff participating in the drill; (4) any problem noted during the drill; and (5) the evacuation time in total minutes. C. If applicable, the local fire department may be requested to supervise and participate in fire drills. [7.8.2.65 NMAC - Rp, 7.8.2.65 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by:	A 065		

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A 065	Continued From page 36 7.8.2.65 A Based on record review and interview, the facility failed to ensure that fire drills were conducted monthly on each eight (8) hour shift (day, evening, night) per quarter. This deficient practice could likely result in 4 (R #s 1 through 4) residents identified on the census, provided the Administrator on 08/17/21, to be at risk of harm, injury, or death if Direct Care Staff (DCS) do not know how to safely evacuate the residents from the building if a fire were to occur. The findings are A. Review request for the facility's fire drill records revealed no documentation that facility had conducted any monthly fire drills. B. On 08/18/21 at 3:30 pm, during an interview with the Administrator she confirmed that the facility had not conducted any monthly fire drills.	A 065	A fire drill was conducted for the month of August. A firedrill will be conducted every month moving foward on different shifts to ensure day/night shift are completing drills. A Fire drill binder has been made to keep track of fire drills. Manager [redacted] will be monitoring on the 3rd week of every month to ensure fire drills are being done in a timely manner.	8/23/21