STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	7028	A. BUILDING: _____ B. WING _____	C 12/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMARAN SENIOR LIVING	9100 HOLLY AVE NE ALBUQUERQUE, NM 87122

(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 12/15/22 for the state requirements of NMAC 7.8.2, Regulations for Assisted Living Facilities. Complaint Intake #NM55452 was unsubstantiated with deficiencies cited. Complaint Intake #NM56906 was unsubstantiated with deficiencies cited.	A 000		
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 refrigerator temperature shall be kept in compliance with the state board of pharmacy	A 034		

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A 034	Continued From page 1 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 pharmacist in accordance with 16.19.11.10 NMAC.	A 034		

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A 034	Continued From page 2 (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: Surveyor: Mascarenas, Brittany 7.8.2.34 A (7) Based on record review and interview, the facility	A 034		

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A 034	Continued From page 3 failed to ensure that they were obtaining PRN (as needed) medication for 3 (R #2-4) of 4 (R #1-4) residents reviewed for medication. This deficient practice could likely result in residents to be at risk of harm if medications, including as needed medications are not available to residents. The findings are: A. On 12/14/22 at 2:45 pm, observation of the medication cart with DCS #3, revealed the following for R#s 2, 3 & 4: 1. R #2 Medications/December MAR (Medication Administration Record) was not in cart. [redacted] 2. R #3 Medication/December 2022 MAR [redacted] 3. R #4 Medication/December 2022 MAR [redacted] B. On 12/14/22 at 2:45 pm, during an interview with DCS #3, she confirmed the findings above. C. On 12/14/22 at 3:00 pm, during an interview with Licensed Practical Nurse (LPN), she confirmed the findings above. to be at risk of injury or death if medication was needed and not readily available.	A 034	Coordinators will conduct a thorough audit to ensure that all PRN medications that are physician ordered are on site and available to our residents. Ongoing, the coordinators will conduct a monthly audit due by the EOM to ensure that all PRN medications that are physician ordered are on site and available to our residents.	1/20/23

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A 034	Continued From page 4 Findings for Oxygen Refer to: NFPA (National Fire Prevention Association) 99. 2012 Edition. 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 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.	A 034		

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A 034	Continued From page 5 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 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	A 034		

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A 034	Continued From page 6 WITHIN (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. Based on observation and interview, the facility failed to ensure that: 1. Oxygen cylinder tanks were stored securely and protected from accidental damage or dislocation. 2. Oxygen cylinder tanks were not stored with combustible materials. 3. Oxygen cylinder tanks were stored no less than 5 ft from combustibles or materials. These deficient practices could likely result in the 68 (R#'s 1-68) residents listed on the resident census, provided by the Business Office Manager on 12/12/22, to be at risk of harm, injury, or death if: 1. 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. 2. Oxygen cylinder tanks were stored with combustibles (plastic bags and plastic tubing) could accelerate the fire. 3. Oxygen cylinder tanks are stored near a source of combustion and there is a fire. The findings are: A. On 12/13/22 at 12:16 pm, during observation of the 2nd floor oxygen storage room, revealed: 1. Five (5) oxygen tanks were not stored in oxygen crates. 2. The three (3) oxygen tanks were stored with	A 034		

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A 034	Continued From page 7 other combustible materials (materials such as cardboard, paper, and other materials that either burn themselves or add heat to a fire). 3. Above the three (3) oxygen tanks was an electrical box that contained multiple frayed wires. B. On 12/15/22 at 1:00 pm, during an exit interview with the Business Office Manager, she confirmed the oxygen tanks were being stored with combustible materials and not protected from accidental damage or dislocation due to not knowing who the tanks belonged to and how to get rid of them.	A 034	All oxygen tanks will be properly secured. No other combustible material will be stored in oxygen storage area. All electrical boxes will be maintained to code. Regular visual inspection has been added to Maintenance Director's task list to ensure ongoing compliance.	1/20/23
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	A 035		

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A 035	Continued From page 8 assist with self-administration of medications shall have successfully completed a state approved assistance with self-administration of medication training program or be licensed or certified by the state board of nursing. C. PRN (pro re nada) medication. (1) Physician or physician extender ' s orders for PRN medications shall clearly indicate the circumstances in which they are to be used, the number of doses that may be given in a 24-hour period and indicate under what circumstances the primary care practitioner (PCP) is to be notified. (2) The utilization of PRN medications shall be reviewed routinely. Frequent or escalating use of 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	A 035		

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A 035	Continued From page 9 include: (1) the resident's name; (2) any known allergies to medication that the resident has; (3) the name of the resident's PCP or the prescriber of the medication; (4) the diagnosis or reason for the medication; (5) the name of the medication, including the drug product brand name and the generic name; (6) notation if the medication is a schedule II-IV drug; (7) the dosage of the medication; (8) the strength of the medication; (9) the frequency or how often the medication is 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.	A 035		

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A 035	Continued From page 11 MEDICATIONS 7.8.2.35 M. Based on record review and interview, the facility failed to ensure for 1 (R #3) of 4 (R #1-4) residents whose facility records were reviewed for compliance that: 1. The correct dosage of the medication was being given; 2. The strength of the medication matched the dosage ordered on the 12/2022 MAR. This deficient practice could potentially affect the health, safety, and welfare of the 68 (R #s 1-68) residents listed on the census provided by the Resident Care Coordinator on 12/13/22, if: 1. A resident is given an excessive dosage of medication. 2. The facility does not report the medication error to the physician and/or prescriber to identify any possible complications and give further instructions. The findings for R #3 are: A. Record review of R #3's facility record, physician order and Medication Administration Record (MAR) for 12/2022, revealed that: 1. R #3 was admitted to the facility on [redacted]22. 2. The following medication ordered for R #3 was the wrong dosage: [redacted] 3. There is no documentary evidence that a medication error report was completed. 4. There is no documentary evidence that the resident's physician was notified. 5. There is no documentary evidence of the	A 035	Clarified orders for medication in question will be obtained. Coordinators will conduct a thorough audit to ensure that all PRN medications that are physician ordered are on site and available to our residents. During that time, they will also audit to ensure that the physician orders match up with the MAR. This process will be repeated monthly, due by the end of the month. Medication staff will receive in service on medication error policy and procedures. Medication errors will be reviewed in bi-weekly Clinical Stand-Up meetings to ensure compliance with P&P's.	1/20/23

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A 035	Continued From page 10 I. If a resident refuses to take a prescribed medication, it shall be documented and the facility shall report it to the prescriber. J. A suspected adverse reaction to a medication shall be documented on the MAR and reported immediately to the PCP and the resident's surrogate decision maker. If applicable, emergency medical treatment shall be arranged. Documentation of the event shall be kept in the resident's record. K. Prescription medication, other than blister packs and unit dose containers, shall be kept in the original container with a pharmacy label that includes the following: (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:	A 035		

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A 035	Continued From page 12 prescriber's response was in R #3's record. B. On 12/15/22 at 12:45 pm, during an interview with the facility's Business Office Manager, she confirmed the above findings for R #3.	A 035		
A 060	7 NMAC 8.2.60 Fire Clearence and Inspections FIRE CLEARANCE AND INSPECTIONS: A. Written documentation of a facility's compliance with applicable fire prevention codes shall be obtained from the state fire marshal ' s office or the fire prevention authority with jurisdiction and shall be submitted to the licensing authority prior to the issuance of an initial license. B. The facility shall request an annual fire inspection from the local fire prevention authorities. If the policy of the local fire department does not provide an annual inspection of the facility, the facility will document the date the request was made and to whom and then contact licensing authorities. If the local fire prevention authorities do make annual inspections, a copy of the latest inspection must be kept on file in the facility. [7.8.2.60 NMAC - Rp, 7.8.2.59 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.60 B Based on record review and interview the facility failed to ensure that the facility had an annual inspection from the Local Fire Authority having jurisdiction. This deficient practice could likely result in the 68 (R #s 1-68) residents listed on the census provided by the Business Office Manager	A 060	Annual Fire Inspection has been completed. Added to our reoccurring task calendar in community physical plant management software.	1/20/23

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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 060	Continued From page 13 on 12/13/22, and all occupants of the building, to be at risk of injury or death if a fire were to occur. The findings are: A. Record review of facility records revealed, that the facility had not had an annual fire inspection from the Local Fire Authority having jurisdiction since 03/30/21. B. On 12/13/22 at 2:50 pm, during an interview with the Business Office Manager, she confirmed that the facility has not had an annual fire inspection from the local fire authority having jurisdiction since 03/30/21.	A 060		
A 065	7 NMAC 8.2.65 Fire Drills FIRE DRILLS: All facilities shall conduct monthly fire drills which are to be documented. A. There shall be at least one (1) documented fire drill per month and at a minimum, one documented fire drill each eight (8) hours (day, evening, night) per quarter that employs the use of the fire alarm system or the detector system in the facility. B. A record of the monthly fire drills shall be maintained on file in the facility and readily available. Fire drill records shall show: (1) the date of the drill; (2) the time of the drill; (3) the number of staff participating in the drill; (4) any problem noted during the drill; and (5) the evacuation time in total minutes. C. If applicable, the local fire department may be requested to supervise and participate in fire drills. [7.8.2.65 NMAC - Rp, 7.8.2.65 NMAC, 01/15/2010]	A 065		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	7028	A. BUILDING: _____ B. WING _____	C 12/15/2022

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A 065	Continued From page 14 This REQUIREMENT is not met as evidenced by: 7.8.2.65 A B (3)(5) Based on record review and interview, the facility failed to ensure that fire drills conducted monthly included the following information: 1. Facility Fire Drills were not conducted in September 2022 and October 2022. 2. The number of staff participating in the fire drill. 3. The evacuation time in total minutes. This deficient practice could likely result in the 68 (R #s 1-68) residents identified on the census, provided by the Business Office Manager on 12/13/22, to be at risk of harm, injury, or death if a fire were to occur and the Direct Care Staff (DCS) do not know how to safely evacuate the residents from the building. The findings are: A. Record review of the facility's fire drill records for the months of September 2022 and October 2022 revealed no documentation that they took place. B. Record review of the facility's fire drill records for the months of November 2022 and December 2022 both revealed: 1. No documentation of the number of staff participating in the fire drill. 2. No documentation of the evacuation time in total minutes. C. On 12/13/22 at 2:30 pm, during an interview with the Business Office Manager, she confirmed that facility fire drills did not take place in September 2022 and October 2022.	A 065	Monthly fire drills are scheduled in community physical plant management software with provision to document number of staff participating and total evacuation time in minutes. Drills will be conducted monthly in accordance with the requirements.	1/20/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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A 065	Continued From page 15 D. On 12/14/22 at 11:15 am, during an interview with the Maintenance Director, he confirmed that the facility fire drill records for the months of November 2022 and December 2022 both did not include documentation of: 1. The number of staff participating in the drill 2. The evacuation time in total minutes.	A 065		