STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2266	A. BUILDING: _____ B. WING _____	C 12/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DESERT PEAKS ASSISTED LIVING AND MEMORY CA	5525 COTTONBLOOM COURT LAS CRUCES, NM 88005

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A 000	Initial Comments The following deficiencies were cited as a result of a Full-Onsite/Complaint survey completed on 12/18/19 for the state requirements of 7 NMAC 8.2, Regulations for Assisted Living Facilities. Complaint Intake NM00038343 was substantiated with deficiencies cited. Complaint Intake NM00038346 was substantiated with deficiencies cited.	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	A 016		

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A 016	Continued From page 1 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 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	A 016		

Division of Health Improvement

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A 016	Continued From page 2 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: This is a repeat deficiency from survey dated 01/08/16. 7.8.2.16 B (3) (7) Refer to 7.1.12 EMPLOYEE ABUSE REGISTRY 7.1.12.8 REGISTRY ESTABLISHED; PROVIDER INQUIRY REQUIRED: Upon the effective date of this rule, the department has established and maintains an accurate and complete electronic registry that contains the name, date of birth, address, social security number, and other appropriate identifying information of all persons who, while employed by a provider, have been determined by the department, as a result of an investigation of a complaint, to have engaged in a substantiated registry-referred incident of abuse, neglect or exploitation of a person receiving care or services from a provider. Additions and updates to the registry shall be posted no later than two (2) business days following receipt. Only department staff designated by the custodian may access, maintain and update the data in the registry. A. Provider requirement to inquire of registry. A provider, prior to employing or contracting with an employee, shall inquire of the registry whether the individual under consideration for employment or contracting is listed on the registry. B. Prohibited employment. A provider may not	A 016	A 016 7 NMAC 8.2.16 Staff Qualifications Staff Qualifications 1. All team member files were audited for the Employee Abuse Registry Clearance (EAR) and the application and fingerprints for the Caregiver Criminal History Screening program (CCHSP). All team members without a current EAR clearance were resubmitted for verification. All team members without fingerprints were submitted by May 15, 2020. 2. The community will monitor the corrective action and ensure ongoing compliance by adhering to the guidelines set forth in regulation A016 7 NMAC 8.2.16 Staff Qualifications; the community will submit for the EAR clearance prior to hiring and starting all team members, and all Criminal History Screening and Fingerprints will be completed within 20 days of hire. The Administrator will utilize a checklist called EAR & CCHSP Tracking to assure compliance with this regulation. (See Addendum 1 attached EAR & CCHSP Tracking.) 3. The corrective action will be completed by May 15, 2020	

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A 016	Continued From page 3 employ or contract with an individual to be an employee if the individual is listed on the registry as having a substantiated registry-referred incident of abuse, neglect or exploitation of a person receiving care or services from a provider. C. Applicant's identifying information required. In making the inquiry to the registry prior to employing or contracting with an employee, the provider shall use identifying information concerning the individual under consideration for employment or contracting sufficient to reasonably and completely search the registry, including the name, address, date of birth, social security number, and other appropriate identifying information required by the registry. D. Documentation of inquiry to registry. The provider shall maintain documentation in the employee's personnel or employment records that evidences the fact that the provider made an inquiry to the registry concerning that employee prior to employment. Such documentation must include evidence, based on the response to such inquiry received from the custodian by the provider, that the employee was not listed on the registry as having a substantiated registry-referred incident of abuse, neglect or exploitation. E. Documentation for other staff. With respect to all employed or contracted individuals providing direct care who are licensed health care professionals or certified nurse aides, the provider shall maintain documentation reflecting the individual's current licensure as a health care professional or current certification as a nurse aide. F. Consequences of noncompliance. The department or other governmental agency having regulatory enforcement authority over a provider may sanction a provider in accordance with applicable law if the provider fails to make an	A 016		

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A 016	Continued From page 4 appropriate and timely inquiry of the registry, or fails to maintain evidence of such inquiry, in connection with the hiring or contracting of an employee; or for employing or contracting any person to work as an employee who is listed on the registry. Such sanctions may include a directed plan of correction, civil monetary penalty not to exceed five thousand dollars ($5000) per instance, or termination or non-renewal of any contract with the department or other governmental agency. [7.1.12.8 NMAC - N, 01/01/2006] 7.1.9.8 CAREGIVER AND HOSPITAL CAREGIVER EMPLOYMENT REQUIREMENTS: . . . D. Application: In order for a nationwide criminal history record to be obtained and processed, the following shall be submitted to the department on forms provided by the department. (1) A form containing personal identification which has a photograph of the person and which meets the requirements for employment eligibility in accordance with the immigration and nationality act as amended. A reasonable xerographic copy of a drivers license photograph will suffice under Subsection D of 7.1.9.8 NMAC. (2) A signed authorization for release of information form. (3) Three (3) complete sets of readable fingerprint cards or other department approved media acceptable to the Department of Public Safety and the Federal Bureau of Investigation submitted using black ink. (4) The fee specified by the department for the nationwide and statewide criminal history screening investigation shall not exceed seventy-four ($74) dollars. Of which, twenty-four ($24) dollars shall be applied for the federal	A 016		

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A 016	Continued From page 5 bureau of investigation nationwide criminal history screening, seven ($7) dollars shall be applied for the statewide criminal history screening. The remaining application fee shall be applied to cover costs incurred by the Department to support activities required by the Act and these rules. The fees will not be applied to any other activity or expense undertaken by the Department. . . . E. Fees: The federal bureau of investigation has a mandatory processing fee with no exceptions. The Department and Department of Public Safety impose a state processing and administrative fee. The fee payment must accompany the fingerprint application, or otherwise be credited to the department prior to or at the same time with the department's receipt of the application documents. The manner of payment of the fee is by bank cashier check or money order payable to the New Mexico Department of Health or other method of funds transfer acceptable to the department. Business checks will be accepted unless the business tendering the check has previously tendered a check to the department unsupported by sufficient funds. Neither cash nor personal checks will be accepted. The fee may be paid by the care provider or by the applicant, caregiver or hospital caregiver. The department will set a fee in addition to the fees imposed by Department of Public Safety and the Federal Bureau of Investigation that will fully and completely cover costs incurred by the department to support activities required by the act and these rules. The fees will not be applied to any other activity or expense undertaken by the department. F. Timely Submission: Care providers shall submit all fees and pertinent application	A 016		

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A 016	Continued From page 6 information for all individuals who meet the definition of an applicant, caregiver or hospital caregiver as described in Subsections B, D and K of 7.1.9.7 NMAC, no later than twenty (20) calendar days from the first day of employment or effective date of a contractual relationship with the care provider. G. Maintenance of Records: Care providers shall maintain documentation relating to all employees and contractors evidencing compliance with the act and these rules. (1) During the term of employment, care providers shall maintain evidence of each applicant, caregiver or hospital caregiver's clearance, pending reconsideration, or disqualification. (2) Care providers shall maintain documented evidence showing the basis for any determination by the care provider that an employee or contractor performs job functions that do not fall within the scope of the requirement for nationwide or statewide criminal history screening. A memorandum in an employee's file stating "This employee does not provide direct care or have routine unsupervised physical or financial access to care recipients served by [name of care provider]," together with the employee's job description, shall suffice for record keeping purposes. Based on record review and interview the facility failed to ensure that: 1. Staff had been cleared by the Employee Abuse Registry (EAR) prior-to-hire. 2. The application and fingerprints for the Caregiver Criminal History Screening program (CCHSP) were submitted within 20 days of the date of hire. This deficient practice has the potential to affect	A 016		

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A 016	Continued From page 7 the safety and welfare of all 34 (R #s 1-34) residents on the census provided by the Administrator on 12/11/19, if they are being provided care by staff who may have a previous history of abusing, neglecting, and/or exploiting residents. The findings are: A. Record review of DCS (Direct Care Staff) #1's (hire date: 01/30/18) employee file revealed, that the EAR clearance application was not submitted/clearance received until 03/21/18, after the date of hire. The documentation revealed the fingerprints were not submitted to the CCHSP until 03/21/18 (50 days after hire date). B. Record review of DCS #2's (hire date: 07/26/18) employee file revealed, that the EAR application was not submitted/clearance received until 08/02/18. C. Record review of DCS #3's (hire date: 12/11/18) employee file revealed, that the EAR application was not submitted/clearance received until 12/17/18. D. Record review of DCS #4's (hire date: 10/09/18) employee file revealed no evidence application and fingerprints were ever submitted to CCHSP and no clearance letter in the file. E. Record review of DCS #5's (hire date: 09/20/18) employee file revealed, that the EAR clearance application was not submitted/clearance received until 11/04/19. There was no documentation that the fingerprints were ever submitted to the CCHSP and no clearance letter in the file. F. Record review of DCS #6's (hire date: 06/13/18) employee file revealed, that the EAR	A 016		

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A 016	Continued From page 8 clearance application was not submitted/clearance received until 07/17/18, after the date of hire. G. Record review of DCS #7's (hire date: 04/17/19) employee file revealed no documentation that the fingerprints were ever submitted to the CCHSP and no clearance letter in the file. H. On 12/12/19 at 9:30 am, during an interview, the Administrator confirmed the above findings listed for DCS #s 1-7 related to EAR clearance and CCHSP clearance.	A 016		
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; (d) appropriate personal hygiene; and (e) infectious and communicable disease control; (4) confidentiality of records and resident	A 017		

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A 017	Continued From page 9 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: This is a repeat deficiency from survey dated 01/08/16. Refer to 7.8.2.17 C (1-2, 4-6, 12) Based on record review and interview the facility failed to ensure that the Direct Care Staff (DCS) received all required annual trainings on the following topics: 1. Fire Safety and evacuation. 2. First Aid. 3. Confidentiality of records and resident information. 4. Infection control. 5. Resident rights. 6. Individual Service Plan (ISP)	A 017	A 017 7 NMAC 8.2.17 Staff Training 1. All team member files were audited to assure required training (12 hours annually) has been completed for all team members and is in the process of being completed. Any team member that has not complied with this regulation will complete all training within 30 days or will not be permitted to work until training is completed. 2. The community will monitor the corrective action and ensure ongoing compliance. Training will take place every month on a set date, during a mandatory all-team meeting. Annual training topics will 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	

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A 017	Continued From page 10 implementation. This deficient practice has the potential for all 34 (R #s 1-34) residents listed on the census provided by the Administrator on 12/11/19, to be at risk of harm or injury if staff have not received all required annual trainings. The findings are: A. Record review of DCS #1's staff file (hire date 01/30/18) revealed no documentation of having received annual training in the proper way to implement a resident ISP for staff that assist with ISPs. B. Record review of DCS #2's staff file (hire date 07/06/18) revealed no documentation of having received annual training in: 1. Fire safety and evacuation. 2. First Aid. 3. Confidentiality of records and resident information. 4. Infection control. 5. The proper way to implement a resident ISP for staff that assist with ISPs. C. Record review of DCS #3's staff file (hire date 12/11/18) revealed no documentation of having received annual training in: 1. Fire safety and evacuation. 2. First Aid. 3. Confidentiality of records and resident information. 4. Resident rights. 5. The proper way to implement a resident ISP for staff that assist with ISPs. C. Record review of DCS #4's staff file (hire date 10/09/18) revealed no documentation of having	A 017	with ISPs. Compliance will be tracked using a spreadsheet called DP Annual Training Tracking 2020 to record and assure that all team members participate in required training monthly. Team members unable to attend training will have the ability to complete training through one-on-one instruction with Presenter (See Addendum attached DP annual Training Tracking 2020.) 3. The corrective action will be implemented by May 15, 2020 and will be reviewed monthly by the Administrator/Wellness Director to assure on-going compliance.	

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A 017	Continued From page 11 received annual training in: 1. First Aid. 2. Confidentiality of records and resident information. 3. The proper way to implement a resident ISP for staff that assist with ISPs. D. On 12/18/19 at 12:37 pm, during an interview, the Administrator confirmed that DCS #s 1-4 had not completed the required annual trainings listed above.	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;	A 020		

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A 020	Continued From page 12 (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 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	A 020		

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	2266	A. BUILDING: _____ B. WING _____	C 12/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DESERT PEAKS ASSISTED LIVING AND MEMORY CA	5525 COTTONBLOOM COURT LAS CRUCES, NM 88005

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A 020	Continued From page 13 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; (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	A 020		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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A 020	Continued From page 14 (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 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	A 020		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DESERT PEAKS ASSISTED LIVING AND MEMORY CA	6525 COTTONBLOOM COURT LAS CRUCES, NM 88005

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A 020	Continued From page 15 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: Refer to 7.8.2.20 A (5, 12-13) Refer to 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	A 020	A 020 7 NMAC 8.2.20 Admissions and Discharge – Revision 1. Desert Peak's Assisted Living and Memory Care Residency Agreement was revised to meet the requirements set forth in Senate Bill 0335-2013. New verbiage was added to address in the regulation, specifically #12; Termination by the community "if" appropriate placement has been found for the resident. Additionally, verbiage was included to address providing 30-day advanced notice of any change in base rent. All residents that needed to sign the Addendum, have signed it. 2. A revision was made to the Residency Agreement to include this information, so all new residents will sign the newest version. 3. The corrective action was completed in June of 2020. (See Addendum attached Residency Agreement and two high-lighted sections, page 1 and page 5 & 6.)	

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A 020	Continued From page 16 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 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 that the Admission/Discharge Agreements included the following information: 1. A refund in case of death policy that is in compliance with SB 0335-2013. 2. The admission/discharge agreement can be terminated by the facility "if" an appropriate placement has been found for the resident. 3. The facility shall provide a thirty day written notice to residents regarding any changes in the cost of the material services provided. These deficient practices have the potential for all 34 (R #s 1-34) residents listed on the census, provided by the Administrator on 12/11/19, to be at risk if the resident, the resident's estate, and or responsible party experience suffering from	A 020		

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A 020	Continued From page 17 emotional/physical/financial hardships by: 1. Not receiving monies owed to them and/or being aware of extra charges that could occur for storage of the residents' belongings. 2. Being discharged before an appropriate placement has been found. 3. Being charged for new/changed care services without the appropriate 30-day notice The findings are: A. Record review of R #s 1, 2, and 4 Admission/Discharge agreements revealed the following: 1. Refund policy for death did not include the provisions set forth with SB 0335 - 2013. 2. The admission/discharge agreement did not include it can be terminated by the facility "if" an appropriate placement has been found for the resident. B. Record review of R # 3's Admission/Discharge agreements revealed the following: 1. Refund policy for death did not include the provisions set forth with SB 0335 - 2013. 2. It did not include it can be terminated by the facility "if" an appropriate placement has been found for the resident. 3. Did not provide 30 days notice to rate increase by stating changes in services rate will apply immediately. C. On 12/17/19 at 2:45 pm, during an interview with the Administrator, she confirmed the above listed findings for R #s 1-4 Admission/Discharge Agreements.	A 020		
A 032	7 NMAC 8.2.32 Reporting of Incidents REPORTING OF INCIDENTS:	A 032		

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A 032	Continued From page 18 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 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: This is a repeat deficiency from survey dated 01/08/16. 7.8.2.32 B (2 & 3)	A 032		

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A 032	Continued From page 19 7.1.13 INCIDENT REPORTING, INTAKE, PROCESSING AND TRAINING REQUIREMENTS Refer to 7.1.13.7 W. & 8 B. (2) W. "Reportable incident" means possible abuse, neglect, exploitation, injuries of unknown origin and other events including but not limited to falls 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. 8 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 2 (R #s 1-2) of 4 (R #s 1-4) residents whose incident reports were reviewed	A 032	A 032 7 NM 8.2.32 Reporting of Incidents 1.Training was conducted with all team members on May 15, 2020. All team members will receive training and receive a copy of Reporting of Incidents Training (see Addendum attached Reporting of Incidents Training.) The training on May 15, 2020, will include the following items: a) The process will be reviewed for conducting and documenting reports of alleged abuse, neglect, exploitation, injuries of unknown origin or other reportable incidents so that all team members understand what is expected. b) All team members received a copy of the bureau's incident report form and were educated as to how to fill it out. c) All incident forms must be received by the division within 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. d) The community will ensure that the person with the most direct involvement and knowledge of the incident will be the person to prepare the incident report. e) The community is responsible for conducting and documenting the investigation of all incidents within 5 days and shall submit a copy of the investigation to the licensing authority. The report shall include the date and time it was submitted to licensing, and a copy shall be kept on file at the community.	

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A 032	Continued From page 20 for compliance that an internal investigation was conducted and a five day follow-up of the incident was filed with the Licensing Authority. This deficient practice has the potential for all residents to be at risk of harm if the facility is not investigating reportable incidents and submitting a investigation report to the Licensing Authority within 5 business days, resulting in no oversite to protect the residents from being abused, neglected, exploited, and/or injured. The findings are: A. Record review of R #1's chart revealed no documentation of a 5 day follow-up investigation report being submitted to the Licensing Authority regarding the incident dated 07/07/19 when medication technicians discovered that R #1's [redacted] B. Record review of R #2's chart revealed no documentation of a 5 day follow-up investigation report being submitted to the Licensing Authority regarding the incident dated 07/07/19 when medication technicians discovered that R #2's [redacted] C. On 12/16/19 at 11:18 am, during an interview with the Administrator, she confirmed that the facility did not submit a investigation/follow-up report within 5 business days to the Licensing Authority for the incidents of missing [redacted] that included the following: (1) 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. (2) Plans for further actions in response to the incident..	A 032	f) The 5 day follow up investigation will include i) a narrative description of the incident ii) The result of the community's investigation shall be recorded on the state approved incident report form for the current year pursuant to 7.1.13 NMAC iii) plans for further actions in response to the incident 2. The Administrator will monitor the corrective action and ensure on-going compliance by reviewing every incident report within 24 hours or the next business day if incident occurred on weekend or holiday. Administrator will also be responsible for assuring 5-day report is completed and submitted within 5 days of the incident occurring. 3. The corrective action will be implemented by May 15, 2020, and will be reviewed by the Administrator frequently to assure on-going compliance.	

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A 034	Continued From page 21	A 034		
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 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.	A 034		

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A 034	Continued From page 22 (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. (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	A 034		

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A 034	Continued From page 23 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 (9) B (2) Based on record review, observation and interview, the facility failed to ensure that: 1. Any remaining medication discontinued by a physician's order was inventoried and moved to a separate locked storage container. 2. Narcotics were stored and inventoried in a manner to enable accurate reconciliation pursuant to Board of Pharmacy Regulations 16.19.11.10 NMAC This deficient practice has the potential for all 34 (R #s 1-34) residents identified on the census provided by the Administrator on 12/11/19 to be	A 034	A 034 7 NMAC 8.2.34 Custodial Drug Permits 1. A full audit of the medication room was conducted on February 14, 2020, by Omnicare Pharmacy. All remaining medications discontinued by a physician's order were inventoried on the D/C MED LOG (see Addendum attached D/C MED LOG) and moved to a separate locked storage container. Narcotic medications are stored and inventoried in a manner to enable accurate reconciliation (see Addendum attached Controlled Substance D/C MED LOG). Medications for Resident 1-4 were inventoried and removed immediately to a separate locked storage container. Medications included: Resident 1 – [redacted] Resident 2 – [redacted] Resident 3 – [redacted] Resident 4 – [redacted] 2. Wellness Director will audit medications in medication room. Reconciliation between orders and what's located in the medication room will take	

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A 034	Continued From page 24 risk for injury or harm due to: 1. Residents receiving the improper medication 2. Narcotics not being available due to lack of accurate reconciliation. The findings are: A. On 12/17/19 at 9:46 am during observation, it was revealed that the following residents had discontinued medications that were still in the medication cart: 1. R #1 [redacted] 2. R #2 [redacted] 3. R #3 [redacted] diarrhea [redacted] 4. R #4 [redacted] B. Record review of R#1-2 medciation files revealed [redacted] were missing due to shift inventory processes not being followed.	A 034	place one time per month by Wellness Director. Administrator will oversee the reconciliation process to assure it takes place monthly. Outside Pharmacy (Omnicare) will conduct an audit monthly, to assure compliance, and quarterly as improvements are made. The Wellness Director or Designee will use the Medication Room Audit form to assure compliance (see Addendum attached MEDICATION ROOM AUDIT FORM). 3. The corrective action will be completed by May 15, 2020 and will be reviewed by the Administrator frequently to assure on-going compliance.	

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	2266	A. BUILDING: _____ B. WING _____	C 12/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DESERT PEAKS ASSISTED LIVING AND MEMORY CA	5525 COTTONBLOOM COURT LAS CRUCES, NM 88005

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A 034	Continued From page 25 C. On 12/17/19 at 10:48 am, during interview, the Administrator confirmed the above listed findings for R #s 1-3 medications.	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 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	A 036		

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A 036	Continued From page 26 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 (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	A 036		

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A 036	Continued From page 27 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 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	A 036		

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A 036	Continued From page 28 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 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,	A 036		

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A 036	Continued From page 29 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. (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	A 036		

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A 036	Continued From page 30 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, 01/15/2010] This REQUIREMENT is not met as evidenced by: Refer to 7.8.2.36 C (4) Based on observation and interview the facility failed to have close fitting lids on 2 refuse containers in the kitchen. This deficient practice has the potential for all 34 (R #s 1-34) residents on the census provided by the Administrator on 12/11/19 to be at risk of contracting foodborne illnesses, by ingesting food contaminated by bacteria and germs. The findings are: A. On 12/18/19 at 7:45 am, during observation and tour of the facility, two refuse containers in the kitchen were observed to not have close fitting covers. B. On 12/18/19 at 10:00 am, during an interview, Cook #1 confirmed the two refuse containers in the kitchen did not have close fitting covers.	A 036	A 036 7 NMAC 8.2.36 Nutrition 1. Immediately following the survey the community purchased 2 lids for the trash cans in the kitchen that did not have lids. All team members were trained on April 15, 2020, on the topic and acknowledged understanding that all garbage and kitchen refuse that is not disposed of through a garbage disposal unit shall be kept in a watertight container with close-fitting covers and disposed of daily in a safe and sanitary manner. (See Addendum attached Nutrition Trash Can Lids.) 2. The Dining Services Director monitors and assures that the lids are placed on garbage cans in the kitchen when not in use during mealtimes. The Dining Services Director or Designee completes the Continuous Quality Improvement form on a monthly basis. (See Addendum attached CQI-dining Survey.) 3. The correction action was completed on January 2, 2020. Compliance will be monitored on-going by the Dining Services Director and the Administrator.	

Division of Health Improvement

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DESERT PEAKS ASSISTED LIVING AND MEMORY CA	5625 COTTONBLOOM COURT LAS CRUCES, NM 88005

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A 043	7 NMAC 8.2.43 Hazardous Areas HAZARDOUS AREAS: Hazardous areas include: Fuel fired equipment rooms (not a typical residential kitchen), bulk laundries or laundry rooms with more than one hundred (100) sq. ft., storage rooms more than fifty (50) sq. ft. but less than one hundred (100) sq. ft. not storing combustibles, storage rooms with more than one hundred (100) sq. ft. storing combustibles, chemical storage rooms with more than fifty (50) sq. ft., garages and maintenance shops/rooms. A. Hazardous areas on the same floor as, and in or abutting, a primary means of escape or a sleeping room shall be protected by either: (1) an enclosure of at least one hour fire rating with self-closing or automatic closing on smoke detection fire doors having a three-quarter (3/4) hour rating; or (2) an automatic fire protection (sprinkler) and separation of hazardous area with self-closing doors or doors with automatic-closing on smoke detection; or (3) other hazardous areas shall be enclosed with walls with at least a twenty (20) minute fire rating and doors equivalent to one and three-quarter (1 3/4) inch solid bonded wood core, operated by self-closures or automatic closing on smoke detection. B. Boiler, furnace or fuel fired water heater rooms. For facilities with four (4) or more residents: all boiler, furnace or fuel fired water heater rooms shall be protected from other parts of the building by construction having a fire resistance rating of not less than one (1) hour. Doors to these rooms shall be one and three-quarter (1-3/4) inch solid core. [7.8.2.43 NMAC - Rp, 7.8.2.44 NMAC, 01/15/2010]	A 043		

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A 043	Continued From page 32 This REQUIREMENT is not met as evidenced by: This is a repeat deficiency from survey dated 01/08/16. Refer to 7.8.2.43 B. Based on observation and interview, the facility failed to ensure that penetrations and holes in two hazardous areas (water heater room and salon) in the ceilings were properly sealed with approved fire suppression material. This deficient practice presents a risk to all 34 (R #s 1-34) residents identified on from the resident census list provided by the Administrator on 12/11/19 and all occupants of the building from smoke and fire passing through the fire rated ceilings in the event of a fire. The findings are: A. On 12/13/19 at 2:28 pm, during observation and tour of the facility with the Head of Maintenance, it was observed that there was a large penetration through the ceiling of the fuel fired water heater room that was not sealed. B. On 12/13/19 at 2:28 pm, in an interview, the Head of Maintenance confirmed that there was a large penetration through the ceiling of the fuel fired water heater room that was not sealed. C. On 12/13/19 at 2:45 pm, during observation and tour of the facility, it was observed that there was a large patched penetration through the ceiling dry wall of the salon room that was not sealed around the seams of the patch. D. On 12/13/19 at 2:45 pm, during an interview, the Head of Maintenance confirmed that there was a large patched penetration through the	A 043	A 043 7 NMAC 8.2.43 Hazardous Areas 1. Patch work in the ceiling of the water heater room and the spa room were completed. (See photo attached in Addendum). 2. The community utilizes a preventative maintenance guide to assure all areas of the community are reviewed on a monthly basis (see Addendum attached Preventative Maint. Task Schedule). The Maintenance Director and Administrator will assure that the repairs to the water heater room and spa room remain intact. 3. The corrective action was completed on February 23, 2020.	

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A 043	Continued From page 33 ceiling dry wall of the salon room that was not sealed around the seams of the patch.	A 043		
A 044	7 NMAC 8.2.44 Heating, Air-Conditioning and Ventilation HEATING, AIR-CONDITIONING AND VENTILATION: A. Heating, air-conditioning, piping, boilers and ventilation equipment shall be furnished, installed and maintained to meet all requirements of current state and local mechanical, electrical and construction codes. All facilities shall have documentation that fuel-fire heating systems have been checked, tested and maintained annually by qualified personnel. B. The heating method used by the facility shall provide a minimum temperature of seventy (70) degrees fahrenheit, measured at three (3) feet above the floor, in all rooms used by the residents. C. No open-face gas or electric heater nor unprotected single shell gas or electric heating device shall be used for heating the facility. Portable heating units shall not be used for heating the facility. All heating appliances shall be permanently anchored and kept away from flammables such as curtains, bedcovering, trash containers, or clothing. No heating appliance shall be located where the unit or wiring is a tripping hazard or presents danger from electrical shock. D. Fireplaces and open flame heating shall not be utilized in sleeping rooms. E. Gas fired water heaters shall not be located in sleeping rooms, bathrooms, or rooms opening into sleeping rooms. F. The facility shall be adequately ventilated at all times to provide fresh air and the control of unpleasant odors by either mechanical or natural	A 044		

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A 044	Continued From page 34 means. G. All openings to the outside air used for ventilation shall be screened for the control of insects and rodents. Screen doors shall be equipped with self-closing devices. H. The facility shall have a system for maintaining the residents comfort during periods of hot weather. Fans shall not be located where the unit or wiring is a tripping hazard. Fans shall be provided with protective shields when there is a potential for contact by any individual. [7.8.2.44 NMAC - Rp, 7.8.2.45 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: Refer to 7.8.2.44 G. Based on observation and interview the facility failed to keep the screens on the windows used for ventilation in good repair. This deficient practice has the potential of harm to all 34 (R #s 1-34) residents from the list provided by the Administrator on 12/11/19 should the opening allow rodents or insects to infest the building. The finding are: A. On 12/18/19 at 8:55 am, during observation and tour of the facility, resident room 116 was observed to have a window screen that had a tear up the whole side of the screen approximately 2 feet long. B. On 12/18/19 at 8:55 am, during an interview, the Head of Maintenance confirmed resident room 116 had a window screen that had a tear up the whole side of the screen approximately 2 feet long.	A 044	A 044 7 NMAC 8.2.44 Heating, Air-Conditioning & Ventilation 1.The torn screen in apartment 116 was repaired. 2. The community Maintenance Director walked each apartment and assessed the condition of all screens. All screens are in good repair. (See attached addendum Window Screesn.) The Maintenance Director will address any window screens in disrepair as soon as possible. 3. The correction action was completed on February 18, 2020.	

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A 049	Continued From page 35	A 049		
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 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	A 049		

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A 049	Continued From page 36 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 a North facing exit door marked as an exit could be readily opened from the inside when locked. This deficient practice has the potential for all 7 (R #s 1-7) memory care residents listed on the resident census provided by the Administrator on 12/11/19, to be at risk of injury or harm if this exit is locked and they are cognitively unable to readily open it in the event of a fire, loss of power, or any emergency that requires evacuation. The findings are: A. On 12/18/19 at 9:00 am, during observation, the North facing exit door in the Memory Care Unit (MCU) did not readily open from the inside when locked and is marked with an exit sign. B. On 12/18/19 at 9:00 am, during interview, the Head of Maintenance confirmed that the North facing exit door in the MCU did not readily open from the inside when locked and is marked with an exit sign.	A 049	A 049 7 NMAC 8.2.49 Doors 1. The north facing door in Memory Care marked as an exit door was modified so it can be readily opened from the inside when locked. An Emergency Push bar was installed on February 21, 2020. (See photo attached in Addendum.) 2. The community will monitor the corrective action by assuring the door is functioning properly at all times. The Maintenance Director will be notified should there be any issues with the door. 3. The correction action was completed on February 21, 2020.	
A 062	7 NMAC 8.2.62 Automatic Fire Protection (Sprinkler) System	A 062		

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A 062	Continued From page 37 AUTOMATIC FIRE PROTECTION (SPRINKLER) SYSTEM: Facilities with nine (9) or more residents shall have an automatic fire protection (sprinkler) system. The system shall be in accordance with NFPA 13 or NFPA 13D or its subsequent replacement as applicable. [7.8.2.62 NMAC - Rp, 7.8.2.61 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: This is a repeat deficiency from survey dated 01/08/16. NFPA 13.6.2.7.1 Plates, escutcheons, or other devices used to cover annular space around a sprinkler shall be metallic or shall be listed for use around a sprinkler. Based on observation and interview the facility failed to ensure the automatic fire sprinkler system had the sprinkler heads maintained in the facility. This deficient practice of not maintaining the automatic sprinkler system has the potential for all 34 (R #s 1-34) residents listed on the census provided by the Administrator on 12/11/19, staff, and visitors to be at risk of harm, injury, or death, if a fire were to occur because the sprinkler heads may not work properly. The findings are: A. On 12/13/19 at 2:28 am, during observation and tour of the facility, the escutcheon around the Fire Sprinkler head was observed to be missing in the salon and the sprinkler head was covered with lint/dirt.	A 062	A 062 7 NMAC 8.2.62 Automatic Fire Protection (Sprinkler) System 1. The missing escutcheon was placed around the fire sprinkler located in the salon. (See attached photo in Addendum.) 2. The community utilizes a preventative maintenance guide to assure all areas of the community are reviewed on a monthly basis (see Addendum attached Preventative Maint. Task Schedule). The Maintenance Director and Administrator will assure that all fire sprinkler escutcheons are in good repair and that the fire sprinklers are without dirt or link. 3. The corrective action was completed on February 23, 2020.	

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A 062	Continued From page 38 B. On 12/18/19 at 9:00 am, during an interview, the Head of Maintenance confirmed the escutcheon around the Fire Sprinkler was missing in the salon and the sprinkler head was covered with lint/dirt.	A 062		
A 063	7 NMAC 8.2.63 Fire Extinguishers FIRE EXTINGUISHERS: Fire extinguisher(s) must be located in the facility, as approved by the state fire marshal or the fire prevention authority with jurisdiction. A. Facilities must as a minimum have two (2) 2A10BC fire extinguishers: (1) one (1) extinguisher located in the kitchen or food preparation area; (2) one (1) extinguisher centrally located in the facility; (3) all fire extinguishers shall be inspected yearly and recharged as needed; all fire extinguishers must be tagged noting the date of the inspection; (4) the maximum distance between fire extinguishers shall be fifty (50) feet. B. Fire extinguishers, alarm systems, automatic detection equipment and other fire fighting equipment shall be properly maintained and inspected as recommended by the manufacturer, state fire marshal, or the local fire authority. [7.8.2.63 NMAC - Rp, 7.8.2.62 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: Refer to 7.8.2.63 A (3) Based on observation and interview, the facility failed to ensure that the fire extinguishers had	A 063	A 063 7 NMAC 8.2.63 Fire Extinguishers 1. The Fire Extinguishers were serviced by an outside vendor in December 2019. 2. The community utilizes a monthly audit tool that calls for the inspection of all fire extinguishers on a monthly basis, as well as on an annual basis by an outside vendor (See Addendum attached Fire Extinguishers.) The Maintenance Director and Administrator will assure that the fire extinguishers are reviewed monthly and annually. 3. The Fire Extinguishers were serviced by an outside vendor in December 2019.	

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A 063	Continued From page 39 been inspected annually to ensure proper working order. This deficient practice has the potential for all 34 (R #s 1-34) residents listed on the census provided by the Administrator on 12/11/19 to be at risk of injury or death if there is a fire and the fire extinguishers do not work properly. The findings are: A. On 12/18/19 at 8:56 am, during observation and tour of the facility, it was observed that fire extinguishers had not been inspected since September 2018 for an annual inspection. B. On 12/18/19 at 8:56 am, during an interview, the Head of Maintenance confirmed that the fire extinguishers had not been inspected since September 2018 for an annual inspection.	A 063		
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.	A 065		

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A 065	Continued From page 40 [7.8.2.65 NMAC - Rp, 7.8.2.65 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: This is a repeat deficiency from survey dated 01/08/16 Refer to 7.8.2.65 A B (5) Based on record review and interview the facility failed to ensure: 1. That at least one fire drill was conducted each month. 2. That a fire drill was conducted during each 8 hour shift (day, evening, night), each quarter (every 3 months). 3. The fire alarm was employed during each monthly fire drill. 4. The evacuation times in total minutes was documented. 5. The date of the drill conducted monthly was documented. This deficient practice has the potential of harm and/or death for all 34 (R #s 1-34) residents identified on the census provided by the Administrator on 12/11/19 if: 1. Staff are out of practice performing fire drills from not doing them monthly. 2. Residents and staff are not accustomed to having drills at all times of the day, evening, and night. 3. Residents and staff are not prepared to respond appropriately, or the alarm fails from lack of use if the fire alarm is not used in all of the fire drills monthly. 4. Staff do not realize that if the evacuation	A 065	A 065 7 NMAC 8.2.65 Fire Drills Fire Drills 1. Fire drills are conducted one time per shift on alternating shifts throughout the quarter (day, swing, nights). 2.The community utilizes a schedule that lists the shifts the fire drills are to run each month (see Addendum attached Fire Drill Shifts). The Maintenance Director and Administrator will assure that all fire drills take place as scheduled and are capture on the correct form (see Addendum attached Fire Drill Record). 3. The corrective action was completed in April 2020 and will take place on-going.	

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A 065	Continued From page 41 time is too lengthy for an efficient and safe evacuation. The findings are: A. Review of the fire drills from December, 2018 through November, 2019 revealed: 1. There was no fire drill conducted in July 2019. 2. There were no fire drills conducted during the 8 hours of the day for the quarter (3 months) from May, 2019 through July,2019. 3. There were no fire drills conducted during the 8 hours of the night for the quarter (3 months) from July, 2019 through September,2019. 4. There were no fire drills conducted during the 8 hours of the day for the quarter (3 months) from September, 2019 through November, 2019. 5. The fire alarm was not used on the drills for 12/31/18, 04/10/no year, 06/20/no year, 09/20/no year, and 10/no date/no year. 6. There was no fire drill completed for the month of 07/10/no year. 7. There were no evacuation times in total minutes. 8. The date of the drill was missing for the day of the month for October and November, 2019, and several were missing the year on the date. 9. There was no year on the date for 4/10/ through 10/no date/no year. B. On 12/13/19 at 2:00 pm, during an interview, the Head of Maintenance confirmed the above findings from the facility's fire drill records.	A 065		
A 068	7 NMAC 8.2.68 Hospice HOSPICE: An assisted living facility that provides	A 068		

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A 068	Continued From page 42 or coordinates hospice care and services shall meet the requirements in this section, in addition to the rules applicable to all assisted living facilities, 7.8.2 NMAC. A. Definitions: in addition to the requirements for all assisted living facilities pursuant to " DEFINITIONS, " 7.8.2.7 NMAC, the following definitions shall also apply. (1) " Hospice agency " means an organization, company, for-profit or non-profit corporation or any other entity which provides a coordinated program of palliative and supportive services for physical, psychological, social and the option of spiritual care of terminally ill people and their families. The services are provided by a medically directed interdisciplinary team in the person's home and the agency is required to be licensed pursuant to 7.12 NMAC. (2) " Hospice care " means a focus on palliative, rather than curative care. The goal of the plan of care is to help the patient live as comfortably as possible, with emphasis on eliminating or decreasing pain and other uncomfortable symptoms. (3) " Licensed assisted living provider " means a facility that provides twenty-four (24) hour assisted living and is licensed by the department of health. (4) " Hospice services " means a program of palliative and supportive services which provides physical, psychological, social and spiritual care for terminally ill patients and their family members. (5) " Care coordination requirements " means a written document that outlines the care and services to be provided by the hospice agency for assisted living residents that require hospice services. (6) " Palliative care " means a form of medical	A 068		

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A 068	Continued From page 43 care or treatment that is intended to reduce the severity of disease symptoms, rather than to reverse progression of the disease itself or provide a cure. (7) " Terminally ill " means a diagnosis by a physician for a patient with a prognosis of six (6) months or less to live. (8) " Visit notes " means the documentation of the services provided for hospice residents and includes ongoing care coordination. B. Employee training and support. A facility that provides hospice services shall provide the following education and training for employees who assist with providing these services: (1) provide a minimum of six (6) hours per year of palliative/hospice care training, which includes one (1) hour specific to the hospice resident ' s ISP, in addition to the basic staff education requirements pursuant to 7.8.2.17 NMAC; and (2) offer an ongoing employee psychological support program for end of life care issues. C. Individual service plan (ISP) requirements. (1) Each resident who receives hospice services shall be provided the necessary palliative care to meet the individual resident ' s needs as outlined in the ISP and shall include one (1) hour of training specific to the resident for all direct care staff. (2) The assisted living facility, in coordination with the hospice provider, shall create an ISP that identifies how the resident's needs are met and includes the following: (a) the requirements set forth in the " Individual Service Plan, " 7.8.2.26 NMAC, and " Exceptions to admission, readmission and retention, " Subsection C of 7.8.2.20 NMAC; (b) what services are to be provided; (c) who will provide the services; (d) how the services will be provided;	A 068		

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A 068	Continued From page 44 (e) a delineation of the role(s) of the hospice provider and the assisted living facility in the ISP process; (f) documentation (visit notes) of the care and services that are provided with the signature of the person who provided the care and services; and (g) a list of the current medications or biologicals that the resident receives and who is authorized to administer them. (3) 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); (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. D. Care coordination. (1) The assisted living facility shall be knowledgeable with regard to the hospice requirements pursuant to 7.12 NMAC and ensure that the hospice agency is well informed with regard to the assisted living provisions pursuant to Subsection C of 7.8.2.20 NMAC. (2) The assisted living facility shall hold a team meeting prior to accepting or retaining a hospice resident in accordance with " Exceptions to admission, readmission and retention, " Subsection C of 7.8.2.20 NMAC. (3) Upon admission of a resident into hospice care, the assisted living facility shall designate a section of the resident ' s record for hospice documentation. (a) The facility shall provide individual records for	A 068		

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A 068	Continued From page 45 each resident. (b) The hospice agency shall leave documentation at the facility in the designated section of the resident ' s record. (4) The assisted living facility shall provide the resident and family or surrogate decision maker with information on palliative care and shall support the resident ' s freedom of choice with regard to decisions. (5) Hospice services shall be available twenty-four (24) hours a day, seven (7) days a week for hospice residents, families and facility staff and may include continuous nursing care for hospice residents as needed. These services shall be delivered in accordance with the resident ' s individual service plan (ISP) and pursuant to 7.8.2 26 NMAC. (6) The assisted living facility shall ensure the coordination of services with the hospice agency. (a) The resident's individual service plan (ISP) shall be updated with significant changes in the resident ' s condition and care needs. (b) The assisted living facility shall receive information and communication from the hospice staff at each visit. (i) The information shall include the resident status and any changes in the ISP (i.e., medication changes, etc.). (ii) The information shall be in the form of a verbal report to the assisted living facility staff and also in the form of written documentation. (c) The assisted living facility or the family/resident shall reserve the right to schedule care conferences as the needs of the resident and family dictate. The care conferences shall include all care team members. (d) Concerns that arise with regard to the delivery of services from either the assisted living facility or the hospice agency shall first be addressed	A 068		

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A 068	Continued From page 46 with the facility administrator and the hospice agency administrator. (i) The process may be informal or formal depending on the nature of the issue. (ii) If an issue can not be resolved or if there is an immediate danger to the resident the appropriate authority shall be notified. E. Additional provisions. An assisted living facility that provides or coordinates hospice care and services shall make additional provisions for the following requirements: (1) individual services and care: each resident receiving hospice services shall be provided the necessary palliative procedures to meet individual needs as defined in the ISP; (2) private visiting space: (a) physical space for private family visits; (b) accommodations for family members to remain with the patient throughout the night; and (c) accommodations for family privacy after a resident ' s death. F. Medicare and medicaid restrictions. Assisted living facilities shall not accept a resident considered " hospice general inpatient " which would be billable to medicare or medicaid because the facility will not qualify for payment by medicare or medicaid. [7.8.2.68 NMAC - N, 01/15/2010] This REQUIREMENT is not met as evidenced by: This is a repeat deficiency from survey dated 01/08/16. Refer to 7.8.2.68 B (1) Based on record review and interview the facility failed to ensure that the Direct Care Staff (DCS) received the required 6 hours of annual	A 068	A 068 7. NMAC 8.2.68 Hospice 1. All team member files were audited to assure required palliative/hospice (6 hours annually) has been completed for all team members and is in the process of being completed. All team members will receive 6 hours of palliative/hospice care training annually. 2. Compliance will be tracked using a spreadsheet called DP Annual Training Tracking 2020 to record and assure that all team members participate in required palliative/hospice training. (See Addendum attached DP Annual Training Tracking 2020). The Administrator and Wellness Director will be responsible for assuring compliance with this regulation and will review the tracking tool monthly and on-going. 3. The corrective action will be completed monthly until all team members complete 6 hours of palliative/hospice training beginning in April 2020.	

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A 068	Continued From page 47 palliative/hospice care [comfort care] training. This deficient practice could negatively effect the health and welfare of all 14 (R #s 1-14) residents who have elected to receive the hospice services by not ensuring the DCS are trained properly. The findings are: A. Record review of the staff file for DCS #1 (hire date 01/30/18) revealed only 2 hours of training in palliative/hospice care in the past year. B. Record review of the staff file for DCS #2 (hire date 07/26/18) revealed only 3 hours of training in palliative/hospice care in the past year. C. Record review of the staff file for DCS #3 (hire date 12/11/18) revealed only 3 hours of training in palliative/hospice care in the past year. D. Record review of the staff file for DCS #4 (hire date 10/09/18) revealed only 3 hours of training in palliative/hospice care in the past year. E. On 12/18/19 at 1:00 pm, in an interview with the Administrator, she confirmed that DCS #s 1-4 had not received the required 6 hours of palliative/hospice training annually.	A 068		
A 069	7 NMAC 8.2.69 Memory Care Units 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.	A 069		

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A 069	Continued From page 48 (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 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	A 069		

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	2266	A. BUILDING: _____ B. WING _____	C 12/18/2019

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A 069	Continued From page 49 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); (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	A 069		

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A 069	Continued From page 50 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. 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).	A 069		

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A 069	Continued From page 51 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 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,	A 069		

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A 069	Continued From page 52 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: Refer to 7.8.2.69 C Based on record review and interview the facility failed to ensure that the Direct Care Staff (DCS) had received the required12 hours of annual Dementia, Alzheimer's disease related trainings. This deficient practice has the potential to negatively effect the health and welfare for all 7 (R #s 1-7) residents identified on the census provided by the Administrator on 12/11/19 as residents in the of the Memory Care Unit by not ensuring the staff are trained properly. The findings are: A. Record review of DCS #1's (hire date 01/30/18) training records revealed only 3 hours of training in the past year related to Dementia	A 069	A 069 Memory Care Units 1. All team member files were audited to assure required Dementia, Alzheimer's Disease related trainings (12 hours annually) has been completed for all team members and is in the process of being completed. All team members will receive 12 hours of Dementia/Alzheimer's care training annually. 2. Compliance will be tracked using a spreadsheet called DP Annual Training Tracking 2020 to record and assure that all team members participate in Dementia, Alzheimer's Disease related required trainings monthly. (See Addendum attached DP Annual Training Tracker 2020). The Administrator and Wellness Director will be responsible for assuring compliance with this regulation and will review the tracking tool monthly and on-going. 3. The corrective action will be completed monthly, beginning in April 2020.	

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A 069	Continued From page 53 and Alzheimer's. B. Record review of DCS #2's (hire date 07/26/18) training records revealed only 2 hours of training in the past year related to Dementia and Alzheimer's. C. Record review of DCS #3's (hire date 12/11/18) training records revealed only 1 hour of training in the past year related to Dementia and Alzheimer's. D. Record review of DCS #4's (hire date 10/09/18) training records revealed only 2 hours of training in the past year related to Dementia and Alzheimer's. E. On 12/18/19 at 1:00 pm, in an interview with the Administrator, she confirmed there was not 12 hours of documentation of training related to Dementia and Alzheimer's for DCS in the past year.	A 069		