| 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 10/22/2024 |

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

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
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| 8 000 | Initial Comments<br><br>The following deficiencies were cited during a Complaint Survey completed on 10/22/24, for the State requirements of NMAC 8.370.14, Regulations for Assisted Living Facilities:<br><br>Complaint #NM[redacted] was investigated and deficiencies were cited.<br>Complaint #NM[redacted] was investigated and deficiencies were cited.<br>Complaint #NM[redacted] was investigated and deficiencies were cited. | 8 000 | | |
| 8 017 | 8 NMAC 370.14.17 Staff Training<br><br>A. Training and orientation for each new employee and volunteer that provides direct care shall include a minimum of 16 hours of supervised training prior to providing unsupervised care for residents.<br>B. Documentation of orientation and subsequent trainings shall be kept in the personnel file at the facility.<br>C. Training shall be provided at orientation and at least 12 hours annually, the orientation, training and proof of competency shall include:<br>(1) fire safety and evacuation training;<br>(2) first aid;<br>(3) safe food handling practices (for persons involved in food preparation), to include:<br>(a) instructions in proper storage;<br>(b) preparation and serving of food;<br>(c) safety in food handling;<br>(d) appropriate personal hygiene; and<br>(e) infectious and communicable disease control;<br>(4) confidentiality of records and resident information;<br>(5) infection control;<br>(6) resident rights;<br>(7) reporting requirements for abuse, neglect or | 8 017 | **Plan of Correction for 8 NMAC 370.14.17 Staff Training**<br><br>The Administrator, under the oversight of the Regional Director, shall initiate an audit of employee files to ensure compliance with state regulations for Desert Peaks. The Administrator will implement an organizational checklist tool to be utilized for all new hires moving forward, which will include the mandatory documentation and training requirements to be completed prior to any new employee commencing work on the floor. This process will entail providing the necessary orientation upon hire, verifying educational backgrounds, and securing certifications to be included in each new hire's file. Furthermore, the maintenance of each staff member's file shall be conducted diligently to prevent any future deficiencies. | 12/03/2024 |

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| 8 017 | Continued From page 1<br>exploitation in accordance with 8.370.9 NMAC;<br>(8) smoking policy for staff, residents and visitors;<br>(9) methods to provide quality resident care;<br>(10) emergency procedures;<br>(11) medication assistance, including the certificate of training for staff that assist with medication delivery; and<br>(12) the proper way to implement a resident ISP for staff that assist with ISPs.<br>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.<br>[8.370.14.17 NMAC - N, 7/1/2024]<br><br>This REQUIREMENT is not met as evidenced by:<br>8.370.14.17 B and C<br><br>Based on record review and interview, the facility failed to ensure staff records for 17( Direct Care Staff #'s 1, 2, 3, 4, 5, and 6 and Medication Technician (Med Tech) #'s 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, and 11) of 17( Direct Care Staff #'s 1, 2, 3, 4, 5, and 6 and Medication Technician (Med Tech) #'s 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, and 11) had the following:<br>1. DCS #4 had received 12 hours of orientation required by the regulation.<br>2. DCS #'s 1, 2, 3, 5, and 6 and Med Tech #'s 1- 11 had received the required annual training.<br>2. DCS #'s 1-6 and Med Tech #'s 1-11 had documentation of orientation and subsequent trainings kept in their personnel file in the facility<br><br>These deficient practices could likely result in harm or injury for 36 (R #s 1-36) residents | 8 017 | | |

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| 8 017 | Continued From page 2<br>identified on the census provided by the Administrator on 10/21/24, if the DCS providing care have not received all required training and do not know how to properly care for residents. The findings are:<br><br>Findings related to 12 hours of orientation and annual trainings required by the regulation:<br><br>A. Record review of DCS #1's personnel file (date of hire 10/22/23) revealed, the record did not contain any documentation of the 12 hours of annual training required by regulation for the following trainings:<br>(1) fire safety and evacuation training<br>(2) first aid<br>(3) safe food handling practices, to include:<br>(a) instructions in proper storage<br>(b) preparation and serving of food<br>(c) safety in food handling<br>(d) appropriate personal hygiene<br>(e) infectious and communicable disease control<br>(4) confidentiality of records and resident information<br>(5) infection control<br>(6) resident rights<br>(7) smoking policy for staff, residents and visitors<br>(8) methods for providing quality resident care<br>(9) emergency procedures<br><br>B. Record review of DCS #2's personnel file (date of hire 01/14/22) revealed, the record did not contain any documentation of the 12 hours of annual training required by the regulation for the following trainings:<br>(1) fire safety and evacuation training<br>(2) first aid | 8 017 | | |

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| 8 017 | Continued From page 3<br>(3) safe food handling practices, to include:<br>(a) instructions in proper storage<br>(b) preparation and serving of food<br>(c) safety in food handling<br>(d) appropriate personal hygiene<br>(e) infectious and communicable disease control<br>(4) confidentiality of records and resident information<br>(5) infection control<br>(6) resident rights<br>(7) smoking policy for staff, residents and visitors<br>(8) methods for providing quality resident care<br>(9) emergency procedures<br><br>C. Record review of DCS #3's personnel file (date of hire 01/22/19) revealed, the record did not contain any documentation of the 12 hours of annual training required by the regulation for the following trainings:<br>(1) fire safety and evacuation training<br>(2) first aid<br>(3) safe food handling practices, to include:<br>(a) instructions in proper storage<br>(b) preparation and serving of food<br>(c) safety in food handling<br>(d) appropriate personal hygiene<br>(e) infectious and communicable disease control<br>(4) confidentiality of records and resident information<br>(5) infection control<br>(6) resident rights<br>(7) smoking policy for staff, residents and visitors<br>(8) methods for providing quality resident care<br>(9) emergency procedures | 8 017 | | |

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| 8 017 | Continued From page 4<br><br>D. Record review of DCS #4's personnel file (date of hire 01/03/24) revealed, the record did not contain any documentation of orientation trainings required by the regulation for the following trainings:<br>(1) fire safety and evacuation training<br>(2) first aid<br>(3) safe food handling practices, to include:<br>(a) instructions in proper storage<br>(b) preparation and serving of food<br>(c) safety in food handling<br>(d) appropriate personal hygiene<br>(e) infectious and communicable disease control<br>(4) confidentiality of records and resident information<br>(5) infection control<br>(6) resident rights<br>(7) smoking policy for staff, residents and visitors<br>(8) methods for providing quality resident care<br>(9) emergency procedures<br>(10) reporting requirements for abuse, neglect, and exploitation<br><br>E. Record review of DCS #5's personnel file (date of hire 07/12/22) revealed, the record did not contain any documentation of the 12 hours of annual training required by the regulation for the following trainings:<br>(1) fire safety and evacuation training<br>(2) first aid<br>(3) safe food handling practices, to include:<br>(a) instructions in proper storage<br>(b) preparation and serving of food<br>(c) safety in food handling<br>(d) appropriate personal hygiene<br>(e) infectious and communicable disease | 8 017 | | |

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| 8 017 | Continued From page 5<br><br>control<br>(4) confidentiality of records and resident information<br>(5) infection control<br>(6) resident rights<br>(7) smoking policy for staff, residents and visitors<br>(8) methods for providing quality resident care<br>(9) emergency procedures<br>(10) reporting requirements for abuse, neglect, and exploitation<br><br>F. Record review of DCS #6's personnel file (date of hire 08/09/21) revealed, the record did not contain any documentation of the 12 hours of annual training required by the regulation for the following trainings:<br>(1) fire safety and evacuation training<br>(2) first aid<br>(3) safe food handling practices, to include:<br>(a) instructions in proper storage<br>(b) preparation and serving of food<br>(c) safety in food handling<br>(d) appropriate personal hygiene<br>(e) infectious and communicable disease control<br>(4) confidentiality of records and resident information<br>(5) infection control<br>(6) resident rights<br>(7) smoking policy for staff, residents and visitors<br>(8) methods for providing quality resident care<br>(9) emergency procedures<br><br>G. Record review of Medication Tech #1's personnel file (date of hire 09/18/23) revealed, the record did not contain any documentation of | 8 017 | | |

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| 8 017 | Continued From page 6<br><br>the 12 hours of annual training required by regulation for the following trainings:<br>(1) fire safety and evacuation training<br>(2) first aid<br>(3) safe food handling practices, to include:<br>(a) instructions in proper storage<br>(b) preparation and serving of food<br>(c) safety in food handling<br>(d) appropriate personal hygiene<br>(e) infectious and communicable disease control<br>(4) confidentiality of records and resident information<br>(5) infection control<br>(6) resident rights<br>(7) reporting requirements for abuse, neglect, or exploitation<br>(8) smoking policy for staff, residents and visitors<br>(9) methods for providing quality resident care<br>(10) emergency procedures<br><br>H. Record review of Medication Tech #2's personnel file (date of hire 11/17/23) revealed the record did not contain any documentation of orientation training required by the regulation for the following trainings:<br>(1) fire safety and evacuation training<br>(2) first aid<br>(3) safe food handling practices, to include:<br>(a) instructions in proper storage<br>(b) preparation and serving of food<br>(c) safety in food handling<br>(d) appropriate personal hygiene<br>(e) infectious and communicable disease control<br>(4) confidentiality of records and resident information<br>(5) infection control | 8 017 | | |

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| 8 017 | Continued From page 7<br>(6) resident rights<br>(7) smoking policy for staff, residents and visitors<br>(8) methods for providing quality resident care<br>(9) emergency procedures<br>(10) reporting requirements for abuse, neglect, or exploitation<br><br>I. Record review of Medication Tech #3's personnel file (date of hire 01/30/18) revealed, the record did not contain any documentation of the 12 hours of annual training required by the regulation for the following trainings:<br>(1) fire safety and evacuation training<br>(2) first aid<br>(3) safe food handling practices, to include:<br>(a) instructions in proper storage<br>(b) preparation and serving of food<br>(c) safety in food handling<br>(d) appropriate personal hygiene<br>(e) infectious and communicable disease control<br>(4) confidentiality of records and resident information<br>(5) infection control<br>(6) resident rights<br>(7) smoking policy for staff, residents and visitors<br>(8) methods for providing quality resident care<br>(9) emergency procedures<br><br>J. Record review of Medication Tech #4's personnel file (date of hire 01/21/20) revealed, the record did not contain any documentation of the 12 hours of annual training required by the regulation for the following trainings:<br>(1) fire safety and evacuation training<br>(2) first aid | 8 017 | | |

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| 8 017 | Continued From page 8<br>(3) safe food handling practices, to include:<br>(a) instructions in proper storage<br>(b) preparation and serving of food<br>(c) safety in food handling<br>(d) appropriate personal hygiene<br>(e) infectious and communicable disease control<br>(4) confidentiality of records and resident information<br>(5) infection control<br>(6) resident rights<br>(7) smoking policy for staff, residents and visitors<br>(8) methods for providing quality resident care<br>(9) emergency procedures<br><br>K. Record review of Medication Tech #5's personnel file (date of hire 01/05/23) revealed, the record did not contain any documentation of the 12 hours of annual training required by the regulation for the following trainings:<br>(1) fire safety and evacuation training<br>(2) first aid<br>(3) safe food handling practices, to include:<br>(a) instructions in proper storage<br>(b) preparation and serving of food<br>(c) safety in food handling<br>(d) appropriate personal hygiene<br>(e) infectious and communicable disease control<br>(4) confidentiality of records and resident information<br>(5) infection control<br>(6) resident rights<br>(7) smoking policy for staff, residents and visitors<br>(8) methods for providing quality resident care<br>(9) emergency procedures | 8 017 | | |

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| 8 017 | Continued From page 9<br><br>L. Record review of Medication Tech #6's personnel file (date of hire 05/18/20) revealed, the record did not contain any documentation of the 12 hours of annual training required by the regulation for the following trainings:<br>(1) fire safety and evacuation training<br>(2) first aid<br>(3) safe food handling practices, to include:<br>(a) instructions in proper storage<br>(b) preparation and serving of food<br>(c) safety in food handling<br>(d) appropriate personal hygiene<br>(e) infectious and communicable disease control<br>(4) confidentiality of records and resident information<br>(5) infection control<br>(6) resident rights<br>(7) smoking policy for staff, residents and visitors<br>(8) methods for providing quality resident care<br>(9) emergency procedures<br><br>M. Record review of Medication Tech #7's personnel file (date of hire 09/01/15) revealed the record did not contain any documentation of the 12 hours of annual training required by the regulation for the following trainings:<br>(1) fire safety and evacuation training<br>(2) first aid<br>(3) safe food handling practices, to include:<br>(a) instructions in proper storage<br>(b) preparation and serving of food<br>(c) safety in food handling<br>(d) appropriate personal hygiene<br>(e) infectious and communicable disease control<br>(4) confidentiality of records and resident | 8 017 | | |

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| 8 017 | Continued From page 10<br>information<br>(5) infection control<br>(6) resident rights<br>(7) smoking policy for staff, residents and visitors<br>(8) methods for providing quality resident care<br>(9) emergency procedures<br>(10) reporting requirements for abuse, neglect, and exploitation<br><br>N. Record review of Medication Tech #8's personnel file (date of hire 06/12/08) revealed the record did not contain any documentation of the 12 hours of annual training required by the regulation for the following trainings:<br>(1) fire safety and evacuation training<br>(2) first aid<br>(3) safe food handling practices, to include:<br>(a) instructions in proper storage<br>(b) preparation and serving of food<br>(c) safety in food handling<br>(d) appropriate personal hygiene<br>(e) infectious and communicable disease control<br>(4) confidentiality of records and resident information<br>(5) infection control<br>(6) resident rights<br>(7) smoking policy for staff, residents and visitors<br>(8) methods for providing quality resident care<br>(9) emergency procedures<br>(10) reporting requirements for abuse, neglect, and exploitation<br><br>O. Record review of Medication Tech #9's personnel file (date of hire 01/26/24) revealed, the record did not contain any documentation of | 8 017 | | |

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| 8 017 | Continued From page 11<br>orientation training required by the regulation for the following trainings:<br>(1) fire safety and evacuation training<br>(2) first aid<br>(3) safe food handling practices, to include:<br>(a) instructions in proper storage<br>(b) preparation and serving of food<br>(c) safety in food handling<br>(d) appropriate personal hygiene<br>(e) infectious and communicable disease control<br>(4) confidentiality of records and resident information<br>(5) infection control<br>(6) resident rights<br>(7) smoking policy for staff, residents and visitors<br>(8) methods for providing quality resident care<br>(9) emergency procedures<br><br>Findings related to documentation of orientation and subsequent trainings kept in the personnel file at the facility:<br><br>P. Record review of DCS #'s 1, 2, 3, 4, 5, and 6 and Med Tech #'s 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, and 11 personnel files did not provide any documentation of any orientation and subsequent trainings kept in their files.<br><br>Q. On 10/22/24 at 8:20 am, during an interview with Administrator, she confirmed that the above listed staff had not received all of their annual or orientation trainings and personnel records were missing documentation of orientation and subsequent trainings. She stated that the personnel files "are a mess". | 8 017 | | |

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| 8 032 | Continued From page 12 | 8 032 | | |
| 8 032 | 8 NMAC 370.14.32 Reporting of Incidents<br><br>A. The facility shall insure that all suspected cases or known incidents of resident abuse, neglect or exploitation are reported in accordance with 8.370.9 NMAC.<br>(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 24 hours or by the next business day, if it is a weekend or a holiday.<br>(2) The facility shall not delay a report to the complaint hotline while an internal investigation is conducted.<br>B. The facility is responsible for conducting and documenting the investigation of all incidents within five 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:<br>(1) a narrative description of the incident;<br>(2) the result of the facility's investigation shall be recorded on the state approved incident report form for the current year, pursuant to 8.370.9 NMAC; and<br>(3) plans for further actions in response to the incident.<br>[8.370.14.32 NMAC - N, 7/1/2024]<br><br>This REQUIREMENT is not met as evidenced by:<br>8.370.14.32 A and B | 8 032 | **Plan of Correction for 8 NMAC 370.14.32 Reporting of Incidents:**<br><br>The Administrator, under the supervision of the Regional Director and in collaboration with the Wellness Director, shall establish and implement appropriate processes and procedures for managing all incidents.<br>The Administrator will facilitate educational training for all staff members, including the Wellness Director and the Wellness team, regarding the proper protocols for incident reporting within the facility and in accordance with state regulations. Furthermore, the Administrator and the Wellness Director shall conduct a thorough review of all incidents within a 24-hour timeframe to ensure that appropriate contacts have been made, follow-up actions have been processed,<br>and that comprehensive investigations are completed both within the facility and by the regulatory agency governing the community. | 12/03/2024 |

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| DESERT PEAKS ASSISTED LIVING AND MEMORY CA | 5525 COTTONBLOOM COURT LAS CRUCES, NM 88005 |

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| 8 032 | Continued From page 13<br><br>8.370.9 Incident Reporting, Intake, Processing and Training Requirements<br>Refer to:<br>8.370.9.7 K M S V<br>K. "Immediate reporting" means reporting that is done as soon as practicable and no later than 24 hours from knowledge of the incident.<br>M. "Incident" means any known, alleged or suspected event of abuse, neglect, exploitation, injuries of unknown origin or other reportable incidents.<br>S. "Neglect" means the failure of the caretaker to provide basic needs of a person, such as clothing, food, shelter, supervision and care for the physical and mental health of that person. Neglect causes, or is likely to cause, harm to a person.<br>V. "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<br><br>8.370.9.8 A B<br>A. Duty to report:<br>(1) All licensed health care facilities shall immediately report abuse, neglect or exploitation to the adult protective services division.<br>(2) All licensed health care facilities shall report abuse, neglect, exploitation, and injuries of unknown origin or other reportable incidents to the bureau within a 24 hour period, or the next business day when the incident occurs on a weekend or holiday.<br>(3) All licensed health care facilities shall ensure that the reporter with direct knowledge of an incident has immediate access to the bureau | 8 032 | | |

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| 8 032 | Continued From page 14<br>incident report form to allow the reporter to respond to, report, and document incidents in a timely and accurate manner.<br><br>B. Notification:<br>(1) Incident reporting: Any person may report an incident to the bureau by utilizing the DHI toll free complaint hotline at 1-800-752-8649. Any consumer, employee, family member or legal guardian may also report an incident to the bureau directly or through the licensed health care facility by written correspondence or by utilizing the bureau's incident report form. The incident report form and instructions for the completion and filing are available at the division's website or may be obtained from the authority by calling the toll free number at 1-800-752-8649.<br>(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 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.<br><br>Based on record review and interview, the facility failed to ensure for 6 (R #'s 1, 2, 3, 4, 5, and 6) of | 8 032 | | |

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| 8 032 | Continued From page 15<br>6 (R #'s 1, 2, 3, 4, 5, and 6) residents whose files, including internal Incident Reports were reviewed for compliance that:<br>1. Incidence of possible abuse, neglect, exploitation, injuries of unknown origin or other reportable incidents, were reported to the Licensing Authority within 24 hours or the next business day, if it is a weekend or a holiday.<br>2. The facility conducted and documented the investigation of all incidents within five business days and submitted a copy of the investigation report to the licensing authority.<br>These deficient practices could likely result in residents to be at risk of harm, injury, and/or death, if incidents occur and there is no oversight by the Licensing Authority.<br><br>The findings are:<br><br>R [redacted]<br><br>A. Record review of R [redacted] Internal Incident Report dated [redacted] revealed the following:<br>1. The resident was in the street in front of the facility<br>2. A police officer helped the resident into his vehicle and brought the resident back to the facility.<br>3. Staff explained to the police officer that the resident attempts to elope often.<br>4. The record did not contain any documentation that the incident was reported to the Licensing Authority.<br><br>R [redacted]<br><br>B. Record review of R [redacted] Internal Incident Report dated [redacted] revealed the following:<br>1. The resident was outside walking towards the road. | 8 032 | | |

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| 8 032 | Continued From page 16<br>2. Staff immediately went and got the resident from the road.<br>3. The record did not contain any documentation that the incident was reported to the Licensing Authority.<br>4. The record did not contain any documentation that there was a follow-up to the resident elopement.<br><br>C. Record review of an Internal Incident Report for R[redacted] dated [redacted] revealed the following:<br>1. On [redacted] walked out of the facility, up the driveway and into the road out front.<br>2. Staff immediately caught up to the resident and redirected [redacted] back into the building.<br>3. The resident's power of attorney (POA), primary care physician (PCP) and administrator were notified of R[redacted] exit seeking behavior.<br>4. The record did not contain any documentation that the incident was reported to the Licensing Authority.<br>5. The record did not contain any documentation that there was a follow-up to the resident elopement.<br><br>D. Record review of an Internal Incident Report for R[redacted] dated [redacted] revealed the following:<br>1. The resident walked out of the facility to the end of the road and proceeded into the roadway.<br>2. A car stopped and assisted the resident out of the road and walked [redacted] o staff into the building.<br>3. R[redacted] OA, PCP, and supervisor were notified.<br>4. "Resident continues to attempt to elope"<br>5. Actions/measures initiated- Alarm to the front door, redirect resident inside<br>6. The record did not contain any documentation that the incident was reported to the Licensing Authority.<br>7. The record did not contain any documentation | 8 032 | | |

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| 8 032 | Continued From page 17<br>that there was a follow-up to the resident elopement.<br><br>E. Record review of an Internal Incident Report for R[redacted] dated [redacted] revealed the following:<br>1. Resident eloped out the front door and walked down the road.<br>2. Two staff and the administrator went out to get the resident<br>3. Resident's POA was verbally notified<br>4. The record did not contain any documentation that the incident was reported to the Licensing Authority.<br>5. The record did not contain any documentation that there was a follow-up to the resident elopement.<br><br>F. Record review of Internal Incident Report for Unwitnessed fall for R[redacted] dated [redacted] revealed the following:<br>1. The record did not contain any documentation that the incident was reported to the Licensing Authority<br>2. The record did not contain any documentation that there was a follow-up to the resident fall.<br><br>G. Record review of Internal Incident Report for R[redacted] dated [redacted] revealed the following:<br>1. Resident had an unwitnessed fall<br>2. No injuries reported<br>3. POA was notified about the fall<br>4. The record did not contain any documentation that the incident was reported to the Licensing Authority.<br>5. The record did not contain any documentation that there was a follow-up to the resident unwitnessed fall.<br><br>H. Record review of the facility's Observation Report for R[redacted] dated [redacted] revealed the | 8 032 | | |

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| 8 032 | Continued From page 18<br>following:<br>1. Resident had two falls in one day<br>2. Injuries were not noted<br>3. PCP was notified<br>4. The record did not contain any documentation that the incident was reported to the Licensing Authority.<br>5. The record did not contain any documentation that there was a follow-up to the resident falls.<br><br>I. Record review of an Observation Report for R [redacted] dated [redacted] revealed the following:<br>1. Resident was found on floor with pillow and blanket and does not remember how [redacted] got on the floor.<br>2. Resident was assessed for visible injuries, and none were noted.<br>3. The resident complained of pain t[redacted] area.<br>4. The record did not contain any documentation that the incident was reported to the Licensing Authority.<br>5. The record did not contain any documentation that there was a follow-up to the resident fall.<br><br>J. Record review of an Observation Report for R [redacted] dated [redacted] evealed the following:<br>1. Resident had a fall<br>2. The record did not contain any documentation that the incident was reported to the Licensing Authority.<br>3. The record did not contain any documentation that there was a follow-up to the resident fall.<br><br>K. Record review of Incident Report for R[redacted] dated [redacted] revealed the following:<br>1. Resident was found outside of the facility and was redirected inside by facility staff.<br>2. Resident exit seeking most of the time, difficult to redirect, lacks safety awareness and is very | 8 032 | | |

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| 8 032 | Continued From page 19<br>mobile and able to leave the facility on [redacted]own.<br>3. The record did not contain any documentation that the incident was reported to the Licensing Authority.<br>4. The record did not contain any documentation that there was a follow-up to the resident elopement<br><br>L. Record review of Observation Report for R[redacted] dated [redacted]revealed the following:<br>1. Resident had a witnessed fall in [redacted]edroom, lost [redacted]balance and fell on [redacted]ght-side hutting the air conditioner.<br>2. Resident's son did not wan[redacted]sent to the hospital.<br>3. The record did not contain any documentation that an incident report was reported to the Licensing Authority.<br>4. The record did not contain any documentation that there was a follow-up to the resident fall.<br><br>M. Record review of Observation Report for R[redacted]date[redacted] revealed the following:<br>1. Resident tripped and fell in hallway outside of office. Resident initially reported no pain. However, continuously moaned as [redacted]vas in pain.<br>2. The record did not contain any documentation that an incident report was reported to the Licensing Authority.<br>3. The record did not contain any documentation that there was a follow-up to the resident fall.<br><br>N. Record review of Observation Report and Internal Incident Report for R[redacted]dated [redacted] revealed the following:<br>1. Resident was found at the end of facility driveway by the main road by a passerby (a person who happens to be going past something). | 8 032 | | |

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| 8 032 | Continued From page 20<br>2. Resident wandered from facility as [redacted]s able to walk with [redacted]walker and open the front door.<br>3. Resident lacks safety awareness and is exit-seeking (a behavior in which a person with dementia tries to leave their home or living facility without a companion) consistently.<br>4. The record did not contain any documentation that an incident report was reported to the Licensing Authority.<br>5. The record did not contain any documentation that there was a follow-up to the resident elopement.<br><br>O. Record review of Internal Incident Report for [redacted] dated [redacted]24 revealed the following:<br>1. Resident was found outside in the front parking lot walking towards the road.<br>2. POA and on call supervisor were notified.<br>3. Resident eloped from facility to driveway.<br>4. Resident lacks safety awareness and has exit-seeking behaviors.<br>5. The record did not contain any documentation that an incident report was reported to the Licensing Authority.<br>6. The record did not contain any documentation that there was a follow-up to the resident elopement.<br><br>P. Record review of Observation Report for R[redacted] dated [redacted]evealed the following:<br>1. Resident had bruising on [redacted]and down [redacted]along with swelling that got worse as the evening unfolded.<br>2. The record did not contain any documentation that an incident report was reported to the Licensing Authority.<br>3. The record did not contain any documentation that there was a follow-up to the resident unexplained injury. | 8 032 | | |

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| 8 032 | Continued From page 21<br><br>Q. Record review of Observation Report for R [redacted] dated [redacted] revealed the following:<br>1. Resident had a fall and found lying [redacted] side on the living room floor.<br>2. POA, [redacted] primary physician and supervisor were notified.<br>3. The record did not contain any documentation that an incident report was reported to the Licensing Authority.<br>4. The record did not contain any documentation that there was a follow-up to the resident fall.<br><br>Findings for R[redacted]<br><br>R. Record review of Observation Report for R [redacted] dated [redacted] revealed the following:<br>1. Resident made concerning comments on how [redacted] third-party caregiver (a person besides the facility involved with the resident care) is very ugly towards [redacted] the resident).<br>2. The record did not contain any documentation that this concern was reported to the Licensing Authority.<br>3. The record did not contain any documentation that the residents concern was investigated by the facility.<br><br>S. Record review of Observation Report for R [redacted] dated [redacted] revealed the following:<br>1. An Incident Report had been completed regarded an Unwitnessed Fall<br>2. The record did not contain any documentation that the unwitnessed fall was reported to the Licensing Authority.<br>3. The record did not contain any documentation that the unwitnessed fall was investigated by the facility.<br><br>T. Record review of Observation Report for R [redacted] dated [redacted] revealed the following: | 8 032 | | |

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| 8 032 | Continued From page 22<br>1. Resident was found wandering in the front parking lot at 11:15 pm.<br>2. The record did not contain any documentation that the elopement was reported to the Licensing Authority.<br>3. The record did not contain any documentation that there was a follow-up to the resident elopement.<br><br>U. Record review of Internal Incident Report for R [redacted] dated [redacted] revealed the following:<br>1. Resident eloped to the back of the facility.<br>2. Resident has a superficial [redacted] o right shoulder blade.<br>3. Resident has had similar incidents<br>4. Resident lacks safety awareness and wanders from the facility and around it.<br>5. Resident is not able to be educated due to mental status.<br>6. The record did not contain any documentation that the elopement was reported to the Licensing Authority.<br>7. The record did not contain any documentation that there was a follow-up to the resident elopement.<br><br>Findings for R[redacted]<br><br>V. Record review of Observation Report for R [redacted] dated [redacted] revealed the following:<br>1. Resident walked out of the building last night while caregiver was taking care of other residents and was redirected back into the facility.<br>2. Resident kept getting out of the facility through all the doors.<br>3. The record did not contain any documentation that the elopement was reported to the Licensing Authority.<br>4. The record did not contain any documentation that there was a follow-up to the resident | 8 032 | | |

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| 8 032 | Continued From page 23<br>elopement.<br><br>W. Record review of Observation Report for R [redacted] dated [redacted] revealed the following:<br>1. Resident continues to wander outside of the facility and required to be redirected into the building.<br>2. Facility staff are to monitor the resident and make sure the door alarms are on.<br>3. The record did not contain any documentation that the elopement was reported to the Licensing Authority.<br>4. The record did not contain any documentation that there was a follow-up to the resident elopement attempts.<br><br>X. Record review of Observation Report for R [redacted] dated [redacted] revealed the following:<br>1. At 5:45 am, the resident was found outside of the building.<br>2. The record did not contain any documentation that the elopement was reported to the Licensing Authority.<br>3. The record did not contain any documentation that there was a follow-up to the resident elopement.<br><br>Y. Record review of Observation Report for R [redacted] dated [redacted] revealed the following:<br>1. The record did not contain any documentation that the injury of unknown source was reported to the Licensing Authority.<br>2. The record did not indicate any documentation that there was a follow-up to the resident injury.<br><br>Z. Record review of Observation Report for R [redacted] dated [redacted] revealed the following:<br>1. The record did not contain any documentation that the unwitnessed fall was reported to the Licensing Authority. | 8 032 | | |

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| 8 032 | Continued From page 24<br>2. The record did not contain any documentation that there was a follow-up to the resident unwitnessed fall.<br><br>Findings for R[redacted]<br><br>AA. Record review of Internal Incident Report for [redacted] dated [redacted] revealed the following:<br>1. Resident started to walk outside, into the highway and into oncoming traffic.<br>2. Resident had been asked to come back to the facility and refused so the sheriff office was called for assistance; staff were able to redirect resident back into the facility.<br>3. Resident has had similar incidents of exit-seeking.<br>4. Resident has low cognitive skills due to dementia.<br>5. The record did not contain any documentation that the incident was reported to the Licensing Authority.<br>6. The record did not contain any documentation that there was a follow-up to the resident incident.<br><br>Findings for R[redacted]<br><br>BB. Record review of Internal Incident Report for R[redacted] dated [redacted] revealed the following:<br>1. Resident was found in front of [redacted] outside window with [redacted]<br>2. Resident appeared disoriented and could no state why [redacted] limbed out of the window.<br>3. Resident has low cognitive skills, repeated falls, and confusion.<br>4. Resident has had recent similar incidents.<br>5. Resident has a [redacted] rom the thigh all the way down to the lower leg and did not go to the hospital.<br>6. The record did not contain any documentation | 8 032 | | |

| 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 10/22/2024 |

| 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 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| 8 032 | Continued From page 25<br>that the incident was reported to the Licensing Authority.<br>7. The record did not contain any documentation that there was a follow-up conducted.<br><br>CC. Record review of Internal Incident Report for R[redacted] dated [redacted] revealed the following:<br>1. Resident was found by a staff member at the end of the driveway at the entrance of the facility at 9:26 pm, resident was helped into a car and transferred back to the building.<br>2. Resident appeared confused and could not state [redacted] was going.<br>3. Physician, family and supervisor was notified<br>4. The record did not contain any documentation that the incident was reported to the Licensing Authority.<br>5. The record did not contain any documentation that there was a follow-up conducted.<br><br>DD. On 10/22/24 at 10:00 am, during an interview with the Administrator and Wellness Director, they both confirmed that the facility had not been reporting resident elopements to the Licensing Authority because they were unaware an elopement was a reportable incident. | 8 032 | | |