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	2043	A. BUILDING: _____ B. WING _____	C 03/13/2025

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8 000	Initial Comments Deficiencies were cited during a Complaint survey completed on 03/13/25 for the state requirements of NMAC 8.370.14, Regulations for Assisted Living for Adults. Census: [redacted] Complaint Intake NM [redacted] was investigated and deficiencies were cited.	8 000		
8 017	8 NMAC 370.14.17 Staff Training 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. 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 12 hours annually, the orientation, training and proof of competency shall include: (1) fire safety and evacuation training; (2) first aid; (3) safe food handling practices (for persons involved in food preparation), to include: (a) instructions in proper storage; (b) preparation and serving of food; (c) safety in food handling; (d) appropriate personal hygiene; and (e) infectious and communicable disease control; (4) confidentiality of records and resident information; (5) infection control; (6) resident rights; (7) reporting requirements for abuse, neglect or exploitation in accordance with 8.370.9 NMAC; (8) smoking policy for staff, residents and visitors;	8 017	8 017 At each monthly meeting the Director will address the required 12 training topics in addition to other current issues involving residents, caregivers and All-Care matters in general. There will be a sign-off sheet for staff signatures. These sheets for January, February, and March have been reviewed and updated. They can be found in the monthly payroll file folders of each staff member. This will be an ongoing procedure and monitored by Director. (see attached)	4/8/25

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8 017	Continued From page 1 (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. [8.370.14.17 NMAC - N, 7/1/2024] This REQUIREMENT is not met as evidenced by: 8.370.14.17 B Based on record review and interview, the facility failed to ensure documentation of orientation and subsequent trainings for facility staff was kept on file and available for review. This deficient practice could negatively affect the safety and welfare of the residents if staff are providing inadequate services due to not completing the required training's. The findings are: A. On 03/13/25 at 7:37am, during an interview, Direct Care Staff (DCS) #1 reported "I started here (at the facility) in November 2024 and training is done monthly. We trained on fire safety and fire drills in January (2025) and we trained on first aid in February (2025)." B. On 03/13/25 at 8:23am, during an interview,	8 017		

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8 017	Continued From page 2 DCS #2 reported "we take our trainings monthly and we trained on fire drills in January (2025) and last month (February 2025) on first aid." C. On 03/13/25 at 10:07am, during an interview, the Administrator (ADM) reported all required annual trainings are broken up into sections, training is conducted on a monthly basis, the sign off sheets for training are kept in the Monthly Payroll and Training Folders. D. Record review of the Monthly Payroll and Training Folders for January 2025 and February 2025 revealed no monthly training sign off sheets were on file. E. On 03/13/25 at 10:20am, during an interview, the ADM confirmed that monthly training sign off sheets were not on file for herself and the other five staff members (Direct Care Staff #1, #2, #3, #4 and #5) for the months of January 2025 and February 2025. F. On 03/20/25 at 12:03pm, during an interview, the ADM reported "all of our mandatory annual trainings are conducted monthly since there are 12 of them listed in the regs (regulations). We trained on fire safety and evacuation training in January (2025) which is the first training listed (in the regulations) and first aid in February (2025) which is the second one (training) listed (in the regulations) and we were not keeping track of that (trainings completed), but we are doing sign off sheets moving forward like I do when they pick up their (staff) checks."	8 017		
8 020	8 NMAC 370.14.20 Admissions and Discharge The facility shall not admit or retain individuals	8 020		

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8 020	Continued From page 3 that require 24 hour continuous nursing care, refer to Subsection U of 8.370.14.7 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	8 020	8 020 A team meeting will be held for a any resident going on Hospice services. The team will consist of resident's surrogate decision maker, facility director, one caregiver, facility nurse if available and resident. Team approval for services will be in writing, signed, and dated by all members. This approval shall be based upon the resident's ISP identify resident's specific needs and addressing how these needs will be met. The director will coordinate the date and time for these meetings. This will be an ongoing procedure for any new residents and current residents needing hospice services. This agreement will be filed in the resident's file folder.	4/10/25

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8 020	Continued From page 4 maker; and (c) the hospice or home health clinician. (2) The team shall jointly determine if the resident should be admitted, readmitted or allowed to remain in the facility. Team approval shall be in writing, signed and dated by all team members and the approval shall be maintained in the resident's record and shall: (a) be based upon an individual service plan (ISP) which identifies the resident's specific needs and addresses the manner that such needs will be met; (b) ensure that if the facility is licensed for more than eight 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); The facility shall not admit or retain individuals that require 24 hour continuous nursing care, refer to Subsection U of 8.370.14.7 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	8 020		

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8 020	Continued From page 5 determined by the PCP; (9) residents with a diagnosis that requires isolation techniques; (10) residents that require the use of a hoyer lift; and (11) ostomy (unless resident is able to provide self-care). C. Exceptions to admission, readmission and retention: If a resident requires a greater degree of care than the facility would normally provide or is permitted to provide and the resident wishes to be re-admitted or remain in the facility and the facility wishes to re-admit or retain the resident. The facility shall comply with the following requirements. (1) Convene a team, comprised of: (a) the facility administrator and a facility health care professional if desired; (b) the resident or resident's surrogate decision maker; and (c) the hospice or home health clinician. (2) The team shall jointly determine if the resident should be admitted, readmitted or allowed to remain in the facility. Team approval shall be in writing, signed and dated by all team members and the approval shall be maintained in the resident's record and shall: (a) be based upon an individual service plan (ISP) which identifies the resident's specific needs and addresses the manner that such needs will be met; (b) ensure that if the facility is licensed for more than eight 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	8 020		

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8 020	Continued From page 6 and the other residents; and (d) include an independent advocate such as a certified ombudsman if requested by the resident, the family or the facility. (3) The team recommendation shall be maintained on site in the resident's file. (4) When a resident is discharged, the facility shall record where the resident was discharged to and what medications were released with the resident. D. Coordination of care: (1) Assisted living facilities shall have evidence of care coordination on an ISP for all services that are provided in the facility by an outside health care provider, such as hospice or home health providers. (2) Residents shall be given a list of providers, including hospice and home health if applicable, and have the right to choose their provider. If applicable, the referring party shall disclose any ownership interest in a recommended or listed provider. [8.370.14.20 NMAC - N, 7/1/2024] This REQUIREMENT is not met as evidenced by: This is a repeat deficiency from a survey dated 07/19/23 8.370.14.20 C (1) (a-c) (2) (a-d) Based on record review and interview, the facility failed to ensure for 2 (R #'s [redacted] and [redacted] of 2 (R #'s [redacted] and [redacted] residents reviewed for hospice care (medical care focused on end of life comfort and quality of life) that a team was convened (of the administrator, the resident or their surrogate decision maker, and the hospice clinician) to jointly determine if the resident should be allowed	8 020		

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8 020	Continued From page 7 to remain at the facility when they were admitted to hospice services. This deficient practice could likely result in staff not implementing the most appropriate care, interventions and treatments needed for the resident. The findings are: A. Record review of R[redacted] Resident Binder revealed R[redacted] started hospice care on [redacted] B. Record review of R[redacted] Resident Binder revealed the record did not contain hospice care team meeting notes. C. Record review of R[redacted] Resident Binder revealed R[redacted] started hospice care on [redacted] D. Record review of R[redacted] Resident Binder revealed the record did not contain hospice care team meeting notes. E. On 03/13/25 at 9:34 am, during an interview, the Administrator (ADM) reported R[redacted] and R[redacted] were on hospice care and a team meeting did not occur for R[redacted] or R[redacted] when they were placed on hospice care. She reported "the hospice company just calls to tell us when they go on hospice and then they come out at least weekly sometimes twice a week to visit the residents."	8 020		
8 027	8 NMAC 370.14.27 Resident Activities Each facility shall provide or make available recreational and social activities appropriate to the residents' abilities that meet their psychosocial needs and are relevant to their	8 027		

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8 027	Continued From page 8 social history; including a balance of cognitive, reminiscence, physical and social activities. The facility shall post the activities and encourage residents to participate. [8.370.14.27 NMAC - N, 7/1/2024] This REQUIREMENT is not met as evidenced by: 8.370.14.27 Based on record review and interview, the facility failed to ensure activities were available for residents and posted for residents to view. These deficient practices could likely cause residents to miss out on participating in activities, which can enrich their social and emotional well-being. The findings are: A. Record review of the facility's posted Activities Calendar revealed activities were not documented for residents. B. On 03/13/25 at 9:40 am, during an interview, R #5 reported "I don't know if we (residents and staff) have anything (activities) planned, but I'm dressed and ready to go anywhere or do anything." C. On 03/13/25 at 1:51 pm, during an interview, R #6 reported "we (residents) don't do activities (at the facility), but I like to go up the way to [name of grocery store] sometimes by myself and sometimes with my friends [first names of R #1 and R #2] like today me and [name of R #2] are going."	8 027	8 027 The Director has designed a recreational and social activity chart appropriate to the resident's abilities. This chart is posted on the board and the staff encourages them to participate The activities will be reviewed and discussed at the monthly meetings for additions and omissions. This is an ongoing process and will be monitored by the Director.	4/3/25

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8 027	Continued From page 9 D. On 03/13/25 at 2:42pm, during an interview, Direct Care Staff (DCS) #3 confirmed that the Activities Calendar posted on the bulletin board near the kitchen table revealed activities were not documented for residents. E. On 03/13/25 at 2:43pm, during an interview, the Administrator (ADM) reported "nothing (activities) is planned they (residents) just do their own thing (activity) like [first name of R #6] and [first name of R #2] just went to the store and [first name of R #4] is sitting out front (on the front porch)." F. On 03/13/25 from 7:15am - 3:15pm and 4:15pm - 4:30pm, observation of the facility revealed there were no activities in progress at the facility.	8 027		
8 033	8 NMAC 370.14.33 Resident Rights All licensed facilities shall understand, protect and respect the rights of all residents. A. Prior to admission to a facility, a resident and legal representative shall be given a written description of the legal rights of the resident, translated into another language, if necessary, to meet the resident's understanding. B. If the resident has no legal representative and is incapable of understanding his or her legal rights, a written copy of the resident's legal rights shall be provided to the most significant responsible party in the following order: (1) the resident's spouse; (2) significant other; (3) any of the resident's adult children; (4) the resident's parents; (5) any relative the resident has lived with for six or more months before admission;	8 033	8 033 All-Care prohibits the use of any and all physical and chemical restraints. The soft restraint was removed and no longer in use as of March 10, 2025. It has been replaced by a motion pad placed under mattress. The monitoring device will be activated any time resident is lying down. The staff will check monitor when laying resident down to confirm it is in working order.	4/3/25

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8 033	Continued From page 10 (6) a person who has been caring for, or paying benefits on behalf of the resident; (7) a placing agency; (8) resident advocate; or (9) the ombudsman. C. The resident rights shall be posted in a conspicuous public place in the facility and shall include the telephone numbers for the incident management hotline and for the state ombudsman program. D. To protect resident rights, the facility shall: (1) treat all residents with courtesy, respect, dignity and compassion; (2) not discriminate in admission or services based on gender, sexual orientation, resident's age, race, religion, physical or mental disability, or nationality; (3) provide residents written information about all services provided by the facility and their costs and give advance written notice of any changes; (4) provide residents with a safe and sanitary living environment; (5) provide humane care for all residents; (6) provide the right to privacy, including privacy during medical examinations, consultations and treatment; (7) protect the confidentiality of the resident's medical record; (8) protect the right to personal privacy, including privacy in personal hygiene; privacy during visits with a spouse, family member or other visitor; and privacy in the resident's own room; (9) protect the right to communicate privately and freely with any person, including private telephone conversations and private correspondence; and the right to receive visits from family, friends, lawyers, ombudsmen and community organizations; (10) prohibit the use of any and all physical and	8 033		

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8 033	Continued From page 11 chemical restraints; (11) ensure that residents: (a) are free from physical and emotional abuse neglect and misappropriation/or exploitation; (b) are free from financial abuse and misappropriation by facility staff or management; (c) are free to participate in religious, social, community and other activities and freely associate with persons in and out of the facility; (d) are free to leave the facility and return without unreasonable restriction; (e) are given a 15 calendar day, written notice before room transfers or discharge from the facility unless there is immediate danger to self or others in the facility; (f) have an environment that fosters social interaction and avoids social isolation; (g) or their surrogate decision makers, are informed of and consent to the services provided by the facility; (h) have the right to voice grievances to the facility staff, public officials, the ombudsmen, any state agency, or any other person, without fear of reprisal or retaliation; (i) have the right to have their complaints addressed within 14 calendar days or sooner; (j) have the right to participate in the development of their care plan/ISP; (k) have the right to choose a doctor, pharmacist and other health care provider(s); (l) have the right to participate in medical treatment decisions and formulate advance directives such as living wills and powers of attorney; (m)have the right to keep and use personal possessions without loss or damage; (n) have the right to manage and control their personal finances; (o) have the right to freely organize and	8 033		

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8 033	Continued From page 12 participate in a resident association that may recommend changes in the facility's policies, services and management; (p) shall not be required to work for the facility; and (q) are protected from unjustified room transfers or discharge. E. The resident's rights shall not be restricted unless this restriction is for the health and safety of the resident, agreed to by the resident or the resident's surrogate decision maker and outlined in the resident's individual service plan. [8.370.14.33 NMAC - N, 7/1/2024] This REQUIREMENT is not met as evidenced by: 8.370.14.33 D (10) Based on record review, observation, and interview, the facility failed to ensure for 1 (R[redacted]) of 1 (R[redacted]) resident diagnosed with Dementia (a decline in cognitive functions including memory, reasoning, and communication skills) was free from the use of physical restraints. This deficient practice could likely place residents at risk of harm if they are injured by a physical restraint or unable to evacuate the facility in the event of an emergency due to the restraint and impaired memory and comprehension. The findings are: A. On 03/12/25 at 1:12 pm, during an interview, the Ombudsman Supervisor Eastern New Mexico (OSENM) stated the Ombudsman Regional Coordinator (ORC) was onsite at the facility on 03/12/25 and observed F[redacted] was tied down to a bed with 4-point restraints (tied down at each limb (4)) and was begging for water. She stated the	8 033		

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8 033	Continued From page 13 Administrator (ADM) and Direct Care Staff (name not provided) stated, "How are we supposed to keep [redacted] from getting up and down?" B. Record review of R[redacted] Evaluation dated 03/08/25, revealed a diagnosis of Dementia. C. Record review of R[redacted] Individual Service Plan (ISP) dated 03/08/25, revealed R[redacted] has "Weakness/attempts to climb out of bed frequently, 2 person transfer only, chest restraint in place while in bed." D. On 03/13/25 at 7:59 am, during an observation, a restraint device (a long strap/belt used to tie down/restrain a person to the bed) was in R[redacted] oom next to [redacted] ed. E. On 03/13/25 at 7:59 am, during an interview, the ADM confirmed the facility had been using the restraint device to restrain the resident: 1. While i[redacted] ed, restraint goes across R [redacted] chest, each end fastened to each (the right and left) half-bedrail. 2. While i[redacted] wheelchair, using a gait belt by going across R [redacted] torso area, with the belt/strap going under both arms on the wheelchair and fastening in the back behind the chair. The ADM stated the last time each restraint was used was 03/11/25, and they had not been using them since, because it was "considered to be a restraint." F. On 03/13/25 at 8:06 am, during an interview, R[redacted] (R[redacted] oommate) stated R[redacted] had been restrained too tightly. Whe[redacted] was restrained you could not even fit two fingers between the restraint and R[redacted] chest. [redacted] stated when R[redacted] was restrained to the wheelchair, it was across [redacted] She stated R[redacted] old the ADM it	8 033		

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	2043	A. BUILDING: _____ B. WING _____	C 03/13/2025

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8 033	Continued From page 14 was too tight, and [redacted] to shut up and did not do anything about it. G. On 03/13/25 at 9:40 am, during an interview, R #5 reported "I saw [first name of R [redacted] sitting in [redacted] wheelchair with a beige strap around [redacted] chest area yesterday, they (the staff) had [redacted] tied down so [redacted] couldn't get up to do anything I guess." H. On 03/13/25 at 9:42 am, during an interview, R [redacted] reported "they had a belt on me yesterday here (motioned with right hand across [redacted] chest from left to right) and it was a little tight." I. On 03/13/25 at 9:45 am, during an interview, R [redacted] reported "I saw [first name of [redacted] tied down in [redacted] wheelchair by a light gray strap around [redacted] waist or stomach area yesterday." J. On 03/13/25 at 4:30 pm, during an interview, the ADM confirmed the restraints had been used on R [redacted] during the night (sleeping hours) and during the day in [redacted] wheelchair when [redacted] would be trying to get up."	8 033		
8 034	8 NMAC 370.14.34 Custodial Drug Permits A facility with two 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	8 034		

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8 034	Continued From page 15 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. (6) The facility shall not require the residents to purchase medications from any 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;	8 034	8 034 The narcotic medications are in a locked drawer. Each medication is accompanied with a control count sheet showing staff signature, date, and time. An exception sheet for errors and refusals can be found in the same place. The staff has had a brief retraining session for recording narcotics and completing exception sheets process. The Director checks these sheets daily. It is an ongoing process for the Director as well as the staff. 4/3/25	

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8 034	Continued From page 16 (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 months, to determine that all medications and records are accurate and current. All irregularities shall be reported to the administrator of the facility and these irregularities shall be resolved by the administrator within 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	8 034		

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8 034	Continued From page 17 requirements for storage, labeling, destruction and documentation of medications as required by the state board of pharmacy, 16.19.11.10 NMAC and 8.370.14 NMAC. [8.370.14.34 NMAC - N, 7/1/2024] This REQUIREMENT is not met as evidenced by: 8.370.14 A (8) G Based on record review, observation, and interview, the facility failed to ensure for 2 (R[redacted] and R[redacted] of 2 (R[redacted] and R[redacted] residents whose medications were reviewed for compliance that narcotic count sheets for medications were reconciled daily to document the accurate balance of the remaining medication. This deficient practice could likely cause harm to residents if they do not receive their medications as prescribed because the medication is not accurately reconciled. The findings are: A. On 03/13/25 at 9:03 am, during an observation of the controlled resident medications, the bubble pack[redacted] B. Record review of the narcotic count sheet for R[redacted] C. Record review of R[redacted] MAR for March 2025 revealed the 12:00 pm dose on 03/08/25 for [redacted] was not initialed by Direct	8 034		

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8 034	Continued From page 18 Care Staff (DCS) and there was no exception sheet (to document a medication error or a refusal). D. On 03/13/25 at 9:06 am, during an observation of the controlled resident medications, the [redacted] E. Record review of the narcotic count sheet for the [redacted] for R [redacted] revealed there were 22 doses left. The count began with 30 on 03/10/25. F. Record review of R [redacted] MAR for March 2025 for the [redacted] evealed the following: 1. The 4 pm dose on 03/10/25 was not initialed by DCS and there was no exception sheet (to document a medication error or refusal). 2. The 8 pm dose on 03/10/25 was not initialed by DCS and there was no exception sheet. 3. The 4 pm dose on 03/11/25 was not initialed by DCS and there was no exception sheet. 4. The 8 pm dose on 03/11/25 was not initialed by DCS and there was no exception sheet. 5. The 4 pm dose on 03/12/25 was not initialed by DCS and there was no exception sheet. 6. The 8 pm dose on 03/12/25 was not initialed by DCS and there was no exception sheet. G. On 03/13/25 at 9:06 am, during an interview, the ADM stated she knew the count was going to	8 034		

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8 034	Continued From page 19 be off for the [redacted] for R [redacted] ADM stated she was not sure what happened with the [redacted] for R [redacted] and was not sure why there was an extra [redacted] for R [redacted] When asked how the counts for the resident's narcotic medications are reconciled everyday, and if it was documented on the MAR, the ADM stated, "I am not sure what happened."	8 034		
8 035	8 NMAC 370.14.35 Medication Administration of medications or staff assistance with self-administration of medications shall be in accordance with state and federal laws. No medications, including over-the-counter medications, PRN (when needed) medications, or treatment shall be started, changed or discontinued by the facility without an order from the physician, physician assistant or nurse practitioner and with entry into the resident's record. A. State board of nursing licensed or certified health care professionals are responsible for the administration of medications. Administration may only be performed by these individuals. B. Facility staff may assist a resident with the self-administration of medications if written consent by the resident is given to the administrator of the facility or the administrator's designee. If the resident is incapable of giving consent, the surrogate decision maker named in accordance with New Mexico law may give written consent for assistance with self-administration of medications. All staff that assist with self-administration of medications shall have successfully completed a state approved assistance with self-administration of medication training program or be licensed or certified by the state board of nursing.	8 035	8 035 The Director has individually spoken to each DCS concerning pre-pouring medication. The director will oversee/monitor medication distribution for 30 days and this will continue to Be an ongoing process by the director. 3/31/25	

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8 035	Continued From page 20 C. PRN (pro re nada) medication: (1) Physician or physician extender's orders for PRN medications shall clearly indicate the circumstances in which they are to be used, the number of doses that may be given in a 24-hour period and indicate under what circumstances the primary care practitioner (PCP) is to be notified. (2) The utilization of PRN medications shall be reviewed routinely. Frequent or escalating use of PRN medications shall be reported to the PCP. D. Only a licensed nurse (RN or LPN) shall administer any medications or conduct any invasive procedures provided by the following routes: intravenous (IV), subcutaneous (SQ), intramuscular (IM), vaginal or rectal. Only a licensed nurse shall administer non-premixed nebulizer treatments. E. The facility shall have medication reference material that contains information relating to drug interactions and side effects on the premises. Staff that assist in the self-administration of medications shall know interactions or possible side effects that might occur. F. Medications prescribed for one resident shall not be used for another resident. G. Medication assistance record (MAR): For residents who are not independent and require assistance with self-administration, the facility shall have a MAR that documents the details of the residents' medication, including PRN and over-the-counter medication that is assisted with self-administration by qualified staff or administered to the resident by licensed or certified staff. The information in the MAR shall include: (1) the resident's name; (2) any known allergies to medication that the resident has; (3) the name of the resident's PCP or the	8 035		

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8 035	Continued From page 21 prescriber of the medication; (4) the diagnosis or reason for the medication; (5) the name of the medication, including the drug product brand name and the generic name; (6) notation if the medication is a schedule II-IV drug; (7) the dosage of the medication; (8) the strength of the medication; (9) the frequency or how often the medication is to be taken or given; (10) the route of delivery for the medication (mouth, eye, ear, other); (11) the method of delivery for the medication (pills, drops, IM injection, other); (12) the date that the medication was started or discontinued; (13) any change in the medication order; (14) pre-medication information (i.e., pulse, respiration, blood pressure, blood sugar) as required by the medication order; (15) the date and time that the medication is self-administered, administered with assistance or is administered; (16) the initials and signature of the person assisting with or administering the medication; (17) the desired results obtained from or problems encountered with the medication (pain relieved, allergic reaction, etc.); (18) any refused dose of medication; (19) any missed dose of medication; and (20) any medication error. H. No medication shall be stopped or started without specific orders from the primary care physician. I. If a resident refuses to take a prescribed medication, it shall be documented and the facility shall report it to the prescriber. J. A suspected adverse reaction to a medication shall be documented on the MAR and reported	8 035		

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8 035	Continued From page 22 immediately to the PCP and the resident's surrogate decision maker. If applicable, emergency medical treatment shall be arranged. Documentation of the event shall be kept in the resident's record. K. Prescription medication, other than blister packs and unit dose containers, shall be kept in the original container with a pharmacy label that includes the following: (1) the resident's name; (2) the name of the medication; (3) the date that the prescription was issued; (4) the prescribed dosage and the instructions for administration of the medication; and (5) the name and title of the prescriber. L. Any medication that is removed from the pharmacy container or blister pack shall be given immediately and documented by the staff that assisted with the medication delivery. M. The facility shall report all medication errors to the physician, documentation of medication errors and the prescriber's response shall be kept in the resident's record. N. The facility shall develop and follow a written policy for unused, outdated, or recalled medications kept in the facility in accordance with 16.19.11.10 NMAC. [8.370.14.35 NMAC - N, 7/1/2024] This REQUIREMENT is not met as evidenced by: 8.370.14.35 G (20) L Based on record review, observation, and interview, the facility failed to ensure for [redacted] (R #'s [redacted] and [redacted] of [redacted] (R #'s [redacted], and [redacted] residents that their medications were not pre-poured and were given to the resident immediately.	8 035		

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8 035	Continued From page 23 This deficient practice could likely cause harm to residents if their medications are pre-poured and a medication error occurs due to the resident getting the wrong medication. The findings are: A. On 03/13/25 at 8:56 am, during an observation of a medication pass, the medications for R #s [redacted] and [redacted] were pre-poured (already dispensed) into medication cups with a piece of masking tape over the top with each resident's name on the tape. B. On 03/13/25 at 8:56 am, during an interview, the Administrator (ADM) stated, "These [referring to the pre-poured medications] were done by [name of DCS/Direct Care Staff #1], and I know we are not supposed to do that."	8 035	8 036 The director has developed a balanced menu for each month and has it posted on the board. The DCS is to follow the menu. An alternative may be given if needed, and it will be noted. The Director will monitor meal preparations for 30 days. This will be an ongoing process for the director.	4/1/25
8 036	8 NMAC 370.14.36 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:	8 036		

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8 036	Continued From page 24 (a) serve at least three meals or their equivalent each day at regular times with no more than 16 hours between the evening meal and morning meal with snacks freely available; (b) provide snacks of nourishing quality and post on the daily menu; (c) develop menus enjoyed by the residents and served at normal intervals appropriate to the residents' preferences; (d) post the weekly menu, including snacks where residents and families are able to view it; posted menus shall be followed and any substitution shall be of equivalent nutritional value and recorded on the posted menu; identical menus shall not be used within a one 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 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	8 036	The facility has 3 refrigerators in the pantry; One freezer in the laundry room and one refrigerator/freezer in the kitchen. All units will have their temperatures logged daily and displayed on the front of the unit. The Director will monitor this process for 30 days and it will become an ongoing process.	

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8 036	Continued From page 25 following documentation onsite: (1) a systematic record of all menus and revisions, including snacks, for a minimum of thirty (30) calendar days; (2) a systematic record of therapeutic diets as prescribed by a PCP; (3) a copy of the most recent licensing inspection and for facilities with 10 or more residents, a copy of the New Mexico environment department inspection with notations made by the facility of action taken to comply with recommendations or citations; and (4) a daily log of the recorded temperatures for all facility refrigerators, freezers and steam tables maintained and available for inspection for 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	8 036		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
8 036	Continued From page 26	8 036		

techniques shall be utilized and understood by the dishwashing staff.
(c) Periodic monitoring of the operation of the detergent dispenser, washing, rinsing and sanitizing temperatures shall be performed and documented.
(d) When a dishwashing machine is utilized, the cleanliness of the machine, its jets and its thermostatic controls shall be monitored and documented by the facility. A monthly log of the recorded temperature of the dishwasher shall be maintained in the facility and available for inspection.
(3) Sinks for hand washing shall include hot and cold running water, hand-washing soap and disposable towels.
(4) All garbage and kitchen refuse that is not disposed of through a garbage disposal unit shall be kept in watertight containers with close-fitting covers and disposed of daily in a safe and sanitary manner.
(5) Cooks and food handlers shall wear clean outer garments and hair nets or caps and shall keep their hands clean at all times when engaged in handling food, drink, utensils or equipment in accordance with the local health authority. Disposable gloves shall be used in accordance 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.
(1) The facility shall ensure that a minimum of a three calendar day supply of perishables and a five 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

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	2043	A. BUILDING: _____ B. WING _____	C 03/13/2025

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8 036	Continued From page 27 not more than plus or minus three 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 35 - 41 degrees fahrenheit. (b) Freezer temperatures shall be maintained at zero 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 calendar days. (4) Steam tables, hot food tables, slow cookers, crock pots and other hot food holding devices shall not be used in heating or reheating food. Hot food temperatures shall be checked periodically to insure that a minimum of 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. (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 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 41 degrees fahrenheit;	8 036		

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8 036	Continued From page 28 (b) the temperature for all hot foods is maintained at 140 degrees fahrenheit; and (c) all displayed or transported food is protected from environmental contamination and maintained at proper temperatures in clean containers, cabinets or serving carts. E. Milk: (1) Raw milk shall not be used. (2) Condensed, evaporated, or dried milk products that are nationally recognized may be employed as "additives" in cooked food preparation but shall not be substituted or served to residents in place of milk. F. Collateral requirements: Compliance with this rule does not relieve a facility from the responsibility of meeting more stringent municipal regulations, ordinances or other requirements of state or federal laws governing food service establishments. Local health authority having jurisdiction means municipal, county, state or federal agency(s) that have laws and regulations governing food establishments, liquid waste disposal, treatment facilities and private wells. [8.370.14.36 NMAC - N, 7/1/2024] This REQUIREMENT is not met as evidenced by: 8.370.14.36 A (1) (d) B (4) Based on record review, observation, and interview, the facility failed to ensure: 1. The weekly menu included all substitutions. 2. Identical menus were not used within a one week cycle. 3. A daily log of the recorded temperatures for refrigerators and freezers was being completed. These deficient practices could likely cause	8 036		

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8 036	Continued From page 29 residents to be unaware of what meal substitutions are available, be limited on meal options each week, and be at risk for foodborne illness (viruses or bacteria causing food poisoning) if temperatures of refrigerators and freezers are not monitored and food becomes contaminated. The findings related to the Menu are: A. Record review of the March 2025 Breakfast Menu revealed no food items listed on a daily basis. B. On 03/13/25 at 7:31am, during an interview, R #1 was observed sitting at the kitchen table eating waffles and sausage. [redacted] reported "I ate the same thing (waffles and sausage) for breakfast yesterday and yesterday for lunch I had nuggets and some kind of shrimp pasta sauce for dinner." C. On 03/13/25 at 7:33am, during an interview, Direct Care Staff (DCS) #1 reported "we do not usually follow the menu especially for breakfast, we just let them (residents) choose what they want to eat or I make it up myself." D. On 03/13/25 at 8:06am, during an interview, the Administrator (ADM) reported "breakfast is the residents choice, whatever they want to eat." E. On 03/13/25 at 8:23am, during an interview, DCS #2 reported "the menu is not really followed it just depends, everyone just kind of tells me what they want to eat". F. On 03/13/25 at 8:31am, during an interview, R #6 reported "I ate waffles and sausage (for breakfast) today and yesterday and shrimp	8 036		

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8 036	Continued From page 30 alfredo for dinner yesterday." G. Record review of the March 2025 Dinner Menu for 03/12/25 revealed lasagna. H. On 3/13/25 at 12:07pm, during an interview, the ADM reported "the residents ate shrimp alfredo for supper yesterday." She confirmed the menu was not followed for dinner/supper yesterday and she did not revise the menu with the substitution. I. Record review of the lunch menu for 03/13/25, revealed lemon honey chx (chicken) with no substitutions documented. J. On 03/13/24 at 12:10pm, during an observation, R#1, R #4 and R #5 were sitting at the kitchen table eating Spam (a brand of lunch meat consisting of processed canned pork and ham), yams and corn. K. On 03/13/25 at 2:41pm, during an interview, DCS #3 confirmed that lemon honey chicken should have been served for lunch today and does not know why it was not and Spam, yams and corn was served instead. DCS #3 reported they (the staff) do not document substitutions on the menu when the menu is not followed. Findings related to the Temperature Logs L. Record review of the temperature logs for the facility freezer near the laundry room revealed it had not been completed for the month of March 2025. The last entry was dated 02/04/25 for the am (morning) check. M. Record review of the refrigerator temperature logs for the 3 refrigerators in the pantry revealed	8 036		

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8 036	Continued From page 31 they had not been completed since 10/20/24. N. On 03/13/24 at 9:48 am, during an interview, the ADM confirmed the temperature logs for the freezer near the laundry room and the 3 refrigerators in the pantry had not been completed daily.	8 036		
8 055	8 NMAC 370.14.55 Toilet and Bathing Facilites Toilet and bathing facilities shall be located appropriately to meet the needs of residents. A. A minimum of one toilet, one sink and one bathing unit shall be provided for every eight residents or fraction thereof. (1) The facility shall provide at least one tub and one shower or combination unit to allow for residents bathing preference. (2) Facilities with four or more residents shall provide a handicap accessible bathroom for every thirty (30) residents that allows for a bathing preference. B. Facilities with four or more residents must comply with accessibility requirements for the disabled. C. Toilet, sink and bathing facilities shall be readily available to the residents. No passage through a resident room by another resident to reach a toilet, bathing unit or sink facility shall be permitted. D. The combination type tub and shower shall be permitted. E. A facility with four or more residents that has live-in staff shall provide a separate toilet, sink and bathing facility for staff. F. Toilets, tubs and showers shall be provided with grab bars. G. Tubs and showers shall have a slip resistant	8 055	8 055 The facility dogs are primarily housed in the sunroom with easy access to the outside. The Director has given the DCSs instructions to sequester them unless they are visiting a resident. The DCS have been instructed to report any bowel or urine to the director immediately to the director. Director will monitor their behavior for 30 days and this will continue as an ongoing process by the Director. 4/1/25 The facility dogs are primarily housed in the sunroom with easy access to the outside. The Director has given the DCSs instructions to sequester them unless they are visiting a resident. The DCS have been instructed to report any bowel or urine to the Director immediately upon discovery. The Director will remove and clean the aforementioned areas. This procedure will be monitored by the Director and it will be an ongoing process.	

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8 055	Continued From page 32 surface. H. The floors of bathrooms and bathing facilities shall have smooth, waterproof and slip-resistant surfaces. I. Toilet paper and soap shall be provided in each toilet room. J. The use of a common towel shall be prohibited. K. Bathrooms and lavatories shall be cleaned as often as necessary to maintain a clean and sanitary condition. [8.370.14.55 NMAC - N, 7/1/2024] This REQUIREMENT is not met as evidenced by: 8.370.14.55 K Based on observation and interview the facility failed to ensure that resident bathrooms were in sanitary conditions and free from animal excrement (feces). This deficient practice could likely cause harm to residents if they are exposed to germs or other bacteria when using the bathrooms causing illness. The findings are: A. On 03/13/25 at 8:05 am, during an observation of the shared bathroom for R[redacted] and [redacted] dry and hardened feces was on the bathroom floor. B. On 03/13/25 at 8:24 am, during an interview, the Administrator (ADM) confirmed there was animal excrement on the shared bathroom floor of R #s[redacted] She reported "that is dog poop from [first name of R[redacted] dog and [redacted] knows	8 055		

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8 055	Continued From page 33 [redacted] should be picking up after [redacted]own dog."	8 055		