Long-Term Care Visits Executive Summary

On May 17 – 19, 2024, representatives from the Department of Health made unannounced visits to ninety-one long-term care facilities (LTC) including assisted living facilities (ALF), skilled nursing facilities (SNF), and nursing facilities (NF). Teams were recruited from ALTSD (14), DDSD (19), and DHI staff (9). A total of forty-two individuals participated in the effort. Eighteen teams were configured with two to three members depending on location. Thirteen counties, or 33% of New Mexico counties, were included in the visits based on location of staffing: Bernalillo, Chaves, Colfax, Curry, Doña Ana, Eddy, McKinley, San Juan, San Miguel, Sandoval, Santa Fe, Taos, and Valencia.

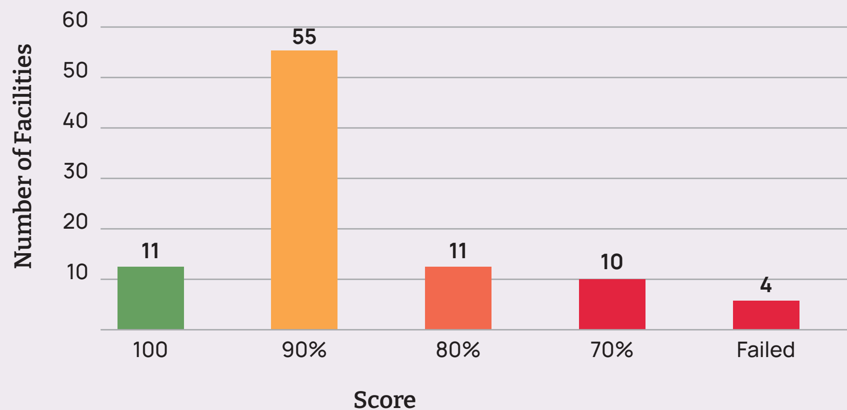
From January 23 to April 24, 56 long-term care facilities had substantiated complaints. 71% (40) were visited during this project.

Types of Facilities Visited

Facility Type	Total Facilities	Number of Visits	Percentage Visited
ALF	213	52	24%
SNF/NF dual	50	34	68%
SNF only	2	2	100%
NF only	3	3	100%
Totals	268	91	34%

Of the 91 facilities scored 4 failed. 2 of those 4 had egregious findings that were reported immediately to the hotline.*

88% of facilities failed some component of the visit.



*Two other facilities have been sent for further review in their annual survey

Case Summary | Las Palomas Center in Albuquerque

At the Las Palomas Center in Albuquerque, one resident directly reported to the evaluator that she was there while her leg healed, but her clothes had been lost in the laundry, and since that time, she was forced to wear a hospital gown. In addition, she had soiled her diaper the evening before and requested assistance at 9:00 pm but did not receive assistance until 9:00 am the following morning.

As a result of this report, the following actions have been taken: The complaint report was investigated with an unannounced visit on 06/14/24. The resident in question had been discharged and the specific allegations in question could not be substantiated. However, the facility underwent a full recertification survey from 07/15-24 in which 32 residents were interviewed about a number of issues. The report is currently being drafted but immediate jeopardy was cited relating to smoking safety which has since been remedied.

Case Summary | Morada ALF in Albuquerque

At the Morada facility in Albuquerque, the two individuals conducting the evaluation stumbled upon a situation where a resident was missing. The resident was later found approximately a mile away from the facility. She was lost, confused, and had fallen. The family was told that she had wandered away previously, but they had not been notified of this incident.

As a result of this report, the following actions have been taken: The complaint was invested with an unannounced visit on 05/20/24. The team was already on site for an unrelated complaint. The allegation of elopement was substantiated and the recorded reflected that the facility had not prevented the recurrence of elopement despite a history of wandering behavior. The facility will be cited for failure to report all elopements to the Licensing Authority and failure to update the Resident Evaluation after the resident eloped. The survey found numerous deficiencies including staff training, individual service plan, medication, nutrition, maintenance of building and grounds, windows, and fire extinguishers. The resident in question has been moved to a memory care unit.

Key Findings

34% of facilities failed to have appropriate signage regarding abuse, neglect, and exploitation reporting.

Over 10% of residents were reported to be unhygienic and similar percentage of facilities **were reported to be unclean**.

Less than 70% of residents were engaged in activities of any type. Frequently residents were watching television and complained about boredom.

Over 25% of facilities provided sub-optimal food for their residents.