STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	325060	A. BUILDING _____ B. WING _____	C 11/19/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PALOMA BLANCA HEALTH AND REHABILITATION	1509 UNIVERSITY BOULEVARD NE ALBUQUERQUE, NM 87102

(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) COMPLETION DATE
F 000	INITIAL COMMENTS The following deficiencies were cited on 11/19/13 as a result of a recertification survey for the requirements of 42 CFR Part 483, Subpart B, requirements for Nursing Facilities. During the survey, one complaint was investigated (NM#29261). The complaint was Unsubstantiated with No Deficiencies.	F 000	*Preparation and submission of this plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or correctness of the conclusions set forth on the statement of deficiencies, the plan of correction is prepared and submitted solely because of the requirements under State and Federal law.* **This Plan of Correction will serve as the Facility's allegation of substantial compliance** 12/30/2013	
F 156 SS=E	483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing. The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section.	F 156	F 156 Resident # 7 has been provided information on how to contact the State Survey and Certification Agency about the care and services received at the facility. The State Survey and Certification Agency information (including names and phone numbers) has been posted in the facility. Current residents have been informed of the posting. The facility leadership team (including social services) will be in-serviced on posting State Agency information in a conspicuous location.	

Scanned 12/24/13 KH

RECEIVED DEC 23 2013 HEALTH FACILITY LICENSING & CERTIFICATION BUREAU

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

Executive Director 12/20/13

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 156	Continued From page 1 The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate. The facility must furnish a written description of legal rights which includes: A description of the manner of protecting personal funds, under paragraph (c) of this section; A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels. A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements.	F 156	The ED/designee will randomly observe the posting to ensure the information remains accessible to residents during renovations. The ED/designee will randomly interview residents weekly x 4 weeks to ensure they are aware of how to contact the State Agency. Results of these audits will be reported to the monthly QAPI committee to ensure substantial compliance.	

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F 156	Continued From page 2 The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care. The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure that one (#7) sampled resident was being informed of her rights (and given information on how) to formally complain to the State Survey and Certification Agency about the care they are receiving. The facility also failed to ensure there were postings of the names, addresses, and telephone numbers of all pertinent State client advocacy group to include the State Survey and Certification Agency. This deficient practice has the potential to prevent cognizant residents from having the information available on how to formally file a complaint with the State Agency. The findings are: A. During observation from 11/12/13 through 11/19/13, there was no posted information in the facility that included names, phone numbers, or addresses that would identify how to formally submit a complaint to the State Survey and Certification Agency.	F 156	*Preparation and submission of this plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or correctness of the conclusions set forth on the statement of deficiencies, the plan of correction is prepared and submitted solely because of the requirements under State and Federal law.* **This Plan of Correction will serve as the Facility's allegation of substantial compliance**	

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F 156	Continued From page 3 B. On 11/13/13 at 2:00 pm, during interview when Resident #7 was asked if the residents have been informed of their right to formally complain to the State agency about the care they are receiving, Resident #7 stated, "That hasn't been on the list of things to take care of. We've had so much change over in the last several months with many Administrators that it has been hard to keep up with. I'm not sure how to do formally file a complaint to the State. I'm not sure how to do that."	F 156		
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or	F 157	F 157 Resident #71's responsible party (RP) will be notified of the resident's changes in condition, including medication changes. Incident Accident investigations (I/A) and MD orders written in the past 30 will be audited to ensure RP notification. Nursing staff will be in-serviced on notification of changes in condition and medication changes.	12/30/2013

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F 157	Continued From page 4 regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to notify the resident's family member of changes in the resident's condition and treatment changes for one resident (#71). This deficient practice has the potential to affect residents' care due to lack of communication with interested parties. The findings are: A. Review of Nurse's Notes dated 10/30/13 indicated that the resident sustained a fall. "Resident on floor in front of wheelchair, resident leaned forward too far. No witnesses. Neuro checks started. Within Normal Limits. Will continue to monitor." There is no documentation indicating that physician and family member were notified. B. On 11/13/13 at 9:52 am, during interview with Resident #71's Responsible Party, he stated that "I have had some concerns regarding this [receiving notification]. In the past they notified me when things were being changed, for example, with her medications. I specifically have asked to be notified when anything is being changed, especially her medications and I have found that this has fallen by the wayside." C. Review of Nurse's Notes dated 11/14/13	F 157	The DCS/designee will review I/A and MD orders during weekly clinical meetings to ensure RP notification. The ED/designee will randomly audit I/A and MD orders weekly x 4 weeks to ensure RP notification. Results of the audit will be reported to the monthly QAPI committee to ensure substantial compliance.	

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F 157	Continued From page 5 indicate: "Resident has been showing increased lethargy during day and sleeping long, Spoke to Dr [doctor] about reviewing medications for possible decrease. Dr decreased Ativan to 0.5 mg tid [three times daily]." There is no documentation indicating that the family member was notified. D. Review of October 2013 Incident/Accident Log indicated that Resident #71 had a fall. There is no documentation indicating that a family member was notified of the incident. E. On 11/13/13 at 9:52 am, during interview with Resident #71's Responsible Party, he stated that "I have had some concerns regarding this [receiving notification]. In the past they notified me when things were being changed, for example, with her medications. I specifically have asked to be notified when anything is being changed, especially her medications and I have found that this has fallen by the wayside." F. On 11/19/13 at 3:22 pm, during interview with the Director of Nursing, she stated that it is facility procedure to notify the resident's responsible party by phone any time there is an accident or change in the resident's condition. She stated that this is then documented in the Nurse's Notes in the resident's medical record. During review of the medical record with the Director of Nursing, she was unable to find documentation to support her statement.	F 157		
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS	F 225		

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F 225	Continued From page 6 The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on record review and interviews, the	F 225	F-225 12/30/2013 Resident #6's transfer status has been re-assessed. The care plan and kardex reflect her current status as 2-person assist with mechanical lift. Resident #11's mobility status has been re-assessed. The care plan and kardex reflect her current status as 1-2 person ADL assist. The C.N.A who failed to follow the resident's plan of care is no longer employed by the facility. The ADON received disciplinary action and is no longer functioning in the capacity of ADON. An audit of current resident transfer/mobility status will be conducted to ensure residents are cared for safely in accordance with their plan of care. Nursing staff will be re-inserviced on: 1) following the resident's plan of care related to transfer/mobility status; 2) facility abuse policy including definitions and reporting.	

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F 225	Continued From page 7 facility failed to immediately report to the Administrator and State Agency (SA) incidents of possible neglect or abuse for 2 (R #6 & #11) of 2 (R #6 & #11) residents. R #6 sustained a head injury while being transferred from the bed to wheelchair via a Hoyer lift [an assistive device that allows patients to be transferred between a bed and a chair]. This incident was not reported or investigated. R #11 reported to staff and her family that a Certified Nursing Assistant (CNA) was "being very rough with her by pulling on her legs while she was hollering for him to stop and who was continuing to hurt her." This incident was not reported. This deficient practice presents a risk of potential harm to resident safety. If incidents of possible neglect or abuse are not reported, the Administrator and SA are not aware of the incident, therefore, they are not able to follow up to ensure resident safety. If incidents of possible neglect are not investigated, the facility is unable to determine what happened in order to prevent it from re-occurring. The findings are: A. Record review for R #6 revealed the following information: 1. Annual History and Physical Examination dated 07/25/13 indicated the resident had medical diagnoses to include paraplegia (paralysis in the lower limbs and trunk of the body), spinal stenosis (an abnormal narrowing of the spinal cord) and who sustained a Cerebrovascular Accident (CVA). 2. Nurse's Notes dated 09/23/13 indicated, "Pt. [patient] fell backwards in her wheelchair this morning when Certified Nursing Assistant (CNA) [who was identified as CNA #1] lifted patients legs. Patient hit the occipital region (area of the back of the head) that resulted in a hematoma.	F 225	The DCS/designee will randomly observe resident transfer and ADLs to ensure staff are following the resident's plan of care 5 x weekly x 4 weeks, then 2 x weekly x 3 months. The ED/designee will randomly observe/interview residents and staff to ensure allegations of possible abuse/neglect are investigated and reported per facility abuse policy 3 x weekly x 4 weeks, then monthly x 3 months. Results of the these audits will be reported to the monthly QAPI committee to ensure facility remains in substantial compliance.	

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F 225	Continued From page 8 Patient reports mild pain at the site of the hematoma. Examination was positive for hematoma and contusion." B. Interviews for R #6 revealed the following information: 1. On 09/27/13 at 11:00 am, during interview R #6 stated, "All I know is that I fell off the wheelchair and was picked up off the floor and I have a big knot on my head now. From what I remember, one man was helping me from the bed to my wheelchair. He was using a Hoyer to lift me. When this happened, he was the only aide who got me out of bed and put me in the wheelchair and I fell straight back onto my head." 2. On 09/27/13 at 11:05 am, during interview CNA #1 stated, "I was transferring [name of R #6] with the Hoyer lift into her wheelchair and when she got into her w/c she was slipping forward. I was transferring her from the bed to the wheelchair by myself. She was very heavy and we need a lot of help to get her up. As she was trying to help me push herself up in the w/c, I was pushing her legs and she fell straight back in her w/c and hit her head on the floor. I knew we needed two people to transfer her from the bed to her w/c. We were supposed to be using two people assist with the Hoyer lift. The problem was I was busy getting people up for breakfast. I knew it was my fault and I know it was our policy to always use two people to transfer her in the Hoyer lift." 3. On 09/27/13 at 11:15 am, during interview the Administrator stated that she would have expected the Assistant Director of Nursing (ADON) to have reported this incident to her when it happened but she did not. 4. On 09/27/13 at 11:45 am, during interview Licensed practical Nurse (LPN) #1 stated, "I was	F 225		

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F 225	Continued From page 9	F 225		

getting report from the night nurse and the CNA told me [name of R #6] was on the floor. So I went in her room and the w/c was on its back and she was lying right next to it on her back. The CNA told me he was lifting the resident into the w/c with the Hoyer lift and he was trying to pull her up in the wheelchair and the wheelchair tipped over and she fell out. She did tell me that she hit her head. She did have a knot at the base of her neck. After that she went to breakfast."

5. On 09/27/13 at 1:40 pm, during interview the Administrator stated, "I'm so upset right now that I'm just being made aware of an incident with one of our employees. I was not informed that the patient fell and hit her head. We even had our morning meeting (on the morning of 09/23/13) and nothing was mentioned to me then. I just learned about this today 09/27/13. What that shows me is when there is a fall of unknown origin we report it to the State. In this case, because care plan was not being followed and there was harm done to the patient, I would have reported it to the State. In my opinion, there was neglect to follow the plan of care and neglect to follow our own policy. There was neglect to follow the plan of care and neglect to follow our own policy. I'm just mortified now to have learned about this now. I was not made aware of this incident when it happened and the resident did sustain actual harm."

C. Record review for R #11 revealed the following:

1. Face Sheet (no date) indicated diagnoses to include Malignant Neoplasm of the Esophagus, Depressive disorder, Mental disorder, and hypertension.

2. The monthly weights documentation form indicated that her current weight was 96.00

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F 225	Continued From page 10 pounds and that she was currently on Hospice. 3. Quarterly Data Collection document (no date) indicated that the resident is non-ambulatory. It further indicated that there was no indicators of severe cognitive impairment and that her mental status was alert and oriented. 4. Admission Minimum Data Set (MDS) dated 05/24/13 indicated that the resident was totally dependent on staff for bed mobility and needed extensive assistance for transfers. 5. A Department of Health Incident Report completed by the Administrator on 09/28/13 (eight days after the incident occurred) indicated that the incident originally occurred on 09/21/13. It further indicated, "Before the incident, patient was receiving care from CNA...when she [R #11] stated he was hurting her and was too rough in conducting ADLs...During the incident, CNA [who was identified as CNA #1] was changing the patient from her night clothes to her day clothes and he was "too rough" in the patients words. The patient cried out 'Help, don't do that. You are hurting me.' But, reports he continued to change her. He also hurt her when he repositioned her in her wheelchair.'" D. Interviews for R #11 revealed the following: 1. On 09/30/13 at 11:15 am, during interview, the Administrator stated, "I just found out about an allegation of physical abuse that a CNA [identified as CNA #1] was rough with [name of R #11]. The resident alleged that the CNA was too rough with her while assisting with Activities of Daily Living (ADL's) and transferring her from the bed to the wheelchair and when repositioning her. The resident stated he was rough with her and hurt her when he moved her and she shouted "'Ouch don't hurt me don't do that.'" The Administrator then stated, when this happened	F 225		

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F 225	Continued From page 11 the resident had gone to the nurses station and stated to my staff that he [referring to CNA #1] was too rough with her. Then the family of the resident came in later stating that she [R #11] had complained about the CNA was too rough with her. The family member had reported this to my Assistant Director of Nursing (ADON) and she failed to follow up with me on this. I was not made aware of this incident when it happened on 09/21/13. Apparently my Director of Nursing (DON) was told on Friday evening 09/27/13 but my DON states that she got an unsealed envelope on her desk with no signature and I barely found out about it on 09/27/13 when the DON put a concern form on my desk." 2. On 09/30/13 at 11:20 am, during interview, the DON stated, "I didn't learn of this until late Friday (09/27/13). It apparently occurred on 09/21/13 on the 6am-6:30pm shift." 3. On 10/01/13 at 12:30 pm, during interview, Hospice Licensed Practical Nurse (LPN) #1 stated, "Her [referring to R #11] physical health is declining to where she cannot bear any weight and she is very contracted [the prevention of mobility of a related joint or tissue]. But her mental state is fine. She is oriented to things." 4. On 10/01/13 at 12:35 pm, during interview, resident #11 stated, "There was a man, a black man who was very rough with me. He was pulling on my legs when he was trying to dress me. I kept hollering for him to stop but he didn't. He kept pushing my legs and hurting me. I told the nurse and I told my family. It happened in the morning time. He was dressing me. He was just hurting me. I asked him to stop. There was no-one else here in my room. All I know, was that I was hurting when he was doing that. I was uncomfortable."	F 225		

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	325060	A. BUILDING _____ B. WING _____	C 11/19/2013

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F 225	Continued From page 12 E. Review of the Facility's Resident Abuse Policy revised 01/01/12 indicated, "No employee may at any time commit an act of physical, psychological, emotional abuse, neglect, mistreatment...against any resident." 1. Definition: Physical Abuse...pulling, or twisting any part of the resident's body...physical contact...through carelessness that results in or is likely to result in...physical injury, pain, or psychological harm to the resident...Indications of psychological harm include...agitation or emotional distress in the resident." 2. Definition: Neglect...Failure to take precautionary measures to protect...the safety of the resident...Failure to provide services that result in harm to the resident...Failure to report observed or suspected abuse, neglect...to the proper authorities." 3. Procedure for Reporting Abuse: "All incidents of resident abuse are to be reported immediately...to the executive director (referring to the Administrator)...The abuse coordinator (facility Administrator) is responsible for reporting to appropriate officials in accordance with Federal and State Regulations."	F 225		
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on record review and interviews, the	F 226	F 226 The ADON received disciplinary action and is no longer functioning in the capacity of ADON.	12/30/2013

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F 226	Continued From page 13 facility failed to implement the written policies and procedures for reporting and investigating possible allegations of abuse and neglect for 2 (R #6 and R #11) of 2 (R #6 and R #11) residents. R #6 sustained a head injury while being transferred via Hoyer lift with only one person instead of the required two, and R #11 who indicated a staff member was being too rough with her during Activity of Daily Living (ADL) care. This deficient practice presents a risk of potential harm to resident safety. If incidents of possible abuse and neglect are not reported, the state agency is not aware of the incident, therefore, the state agency is not able to follow up with the facility to ensure resident safety. If incidents of possible abuse and neglect are not investigated, the facility is unable to determine what happened in order to prevent it from re-occurring. If the five day follow-up investigation is not submitted, the State Survey and Certification Agency is not able to determine whether or not a thorough investigation was completed to ensure resident safety. The findings are: A. Review of the Facility's Resident Abuse Policy revised 01/01/12 indicated, "No employee may at any time commit an act of physical, psychological, emotional abuse, neglect, mistreatment...against any resident." 1. Definition: Physical Abuse...pulling, or twisting any part of the resident's body...physical contact...through carelessness that results in or is likely to result in...physical injury, pain, or psychological harm to the resident...Indications of psychological harm include...agitation or emotional distress in the resident." 2. Definition: Neglect...Failure to take precautionary measures to protect...the safety of the resident...Failure to provide services that	F 226	Resident, family, and staff concerns reported in the past 30 days will be reviewed to ensure allegations of possible abuse/neglect have been managed according to the facility abuse policy. Facility staff will be re-educated on the facility abuse policy as it relates to implementing timely reporting and investigation. The ED/designee will review resident, family and staff complaints and I/A reports to ensure possible allegations of abuse/neglect are managed according to the facility's abuse policy. Concerns, complaints, and I/A will be reported to the monthly QAPI committee to ensure the facility remains in substantial compliance.	

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F 226	Continued From page 14 result in harm to the resident...Failure to report observed or suspected abuse, neglect...to the proper authorities." 3. Procedure for Reporting Abuse: "All incidents of resident abuse are to be reported immediately...to the executive director (referring to the Administrator)...The abuse coordinator (facility Administrator) is responsible for reporting to appropriate officials in accordance with Federal and State Regulations." B. Record review and interview for Resident R #6 revealed the following: 1. Nurse's Notes dated 09/23/13 indicated, "Pt. [patient] fell backwards in her wheelchair this morning when Certified Nursing Assistant (CNA) [who was identified as CNA #1] lifted patients legs. Patient hit the occipital region (area of the back of the head) that resulted in a hematoma (swelling with containing blood). Patient reports mild pain at the site of the hematoma. Examination was positive for hematoma and contusion." 2. On 09/27/13 at 11:15 am, during interview the Administrator stated that she would have expected the Assistant Director of Nursing (ADON) to have reported this incident to her when it happened but she did not. 3. On 09/27/13 at 1:40 pm, during interview the Administrator stated, "I'm so upset right now that I'm just being made aware of an incident with one of our employees. I was not informed that the patient fell and hit her head. We even had our morning meeting (on the morning of 09/23/13) and nothing was mentioned to me then. I just learned about this today 09/27/13. What that shows me is when there is a fall of unknown origin we report it to the State. In this case, since	F 226		

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F 226	Continued From page 15	F 226		

there was harm done to the patient, I would have reported it to the State. In my opinion, neglect to follow our own policy. I'm just mortified now to have learned about this now. I was not made aware of this incident when it happened and the resident did sustain actual harm."

C. Record review and interviews for Resident R #11 revealed the following:

1. A Department of Health Incident Report completed by the Administrator on 09/28/13 indicated that this incident (of physical abuse)originally occurred on 09/21/13. It further indicated, "Before the incident, patient was receiving care from from CNA [identified as CNA #1]...when she [R #11]....when she stated he was hurting her and was too rough in conducting ADLs...During the incident, CNA [identified as CNA #1] was changing the patient from her night clothes to her day clothes and he was "too rough" in the patients words. The patient cried out 'Help, don't do that. You are hurting me.' But, reports he continued to change her. He also hurt her when he repositioned her in her wheelchair.'"

2. On 09/30/13 at 11:15 am, during interview, the Administrator stated, "I just found out about an allegation of physical abuse that a CNA [identified as CNA #1] was rough with [name of R #11]. The resident alleged that the CNA #1 was too rough with her while assisting with Activities of Daily Living (ADL's) and transferring her from the bed to the wheelchair and when repositioning her. The resident stated he was rough with her and hurt her when he moved her and she shouted '"Ouch don't hurt me don't do that."' The Administrator then stated, when this happened the resident had gone to the nurses station and stated to my staff that he [the CNA #1] was too

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F 226	Continued From page 16 rough with her. The the family of the resident came in later stating that the resident had complained about the CNA #1 was too rough with her. The family member had reported this to my Assistant Director of Nursing (ADON) and she failed to follow up with me on this. The Administrator then stated, "I was not made aware of this indicant when it happened on 09/21/13." 3. On 09/30/13 at 11:20 am, during interview with Director of Nursing (DON) stated, "I didn't learn of this until late Friday (09/27/13). It apparently occurred on 09/21/13 on the 6am-6:30pm shift." 4. On 10/01/13 at 12:35 pm, during interview R #11 stated, "There was a man, a black man who was very rough with me. He was pulling on my legs when he was trying to dress me. I kept hollering for him to stop but he didn't. He kept pushing my legs and hurting me. I told the nurse and I told my family. It happened in the morning time. He was dressing me. He was just hurting me. I asked him to stop. There was no-one else here in my room. All I know was that I was hurting when he was doing that. I was uncomfortable."	F 226		
F 244 SS=D	483.15(c)(6) LISTEN/ACT ON GROUP GRIEVANCE/RECOMMENDATION When a resident or family group exists, the facility must listen to the views and act upon the grievances and recommendations of residents and families concerning proposed policy and operational decisions affecting resident care and life in the facility. This REQUIREMENT is not met as evidenced by:	F 244	F 244 Resident #7's concerns will be acted upon when presented to the facility administration or voiced at the resident council meeting.	12/30/2013

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F 244	Continued From page 17 Based on observation, record review and interview the facility failed to act upon grievances for one (#7) of one Resident Council members when concerns were discussed in the resident council meetings. This deficient practice is a violation of resident rights and could likely cause the residents to feel their concerns are not important or worth acting upon. The findings are: A. Record Review Resident #7's revealed the following: 1. Care Plan notes (not dated) indicated that the resident actively participates in many activities. 2. Activities Assessment (not dated) further indicated her many skills and interests and the activity log notes good participation. B. On 11/13/13 at 2:00 pm, during interview when Resident #7 was asked if the staff listened to the Resident Council's concerns and acts upon any grievances the resident/group has filed, Resident #7 stated, "I would say no, we've been dealing with a lot lately. I'm having to try to come up with programs for us [referring to the residents] to do such as the Christmas dinner. For example, with our Resident Council meeting we had yesterday, with the activities, everyone was angry because of the activity budget for 2014. We were told that beginning in January 2014, we will no longer have money for activities. They took activities away from us, but yet they can pay for a newsletter and a calender. Our activities program is very poor. It's the weekends that is a problem especially on Saturdays. We just have Bingo on Saturdays and Sunday we have mass and that is it. I think we need something more in case a person doesn't want to	F 244	Concerns from current residents in the past 30 days (including resident council) will be audited to ensure they have been satisfactorily addressed. Activity programming will be discussed at the next resident counsel meeting to obtain resident input for future programs during evenings and weekends. The ED/designee will randomly observe and interview residents to ensure activity programming is meeting their expectations weekly x 4 weeks, then monthly x 2 months. Results of these observations and interviews will be reported to the monthly QAPI committee to ensure substantial compliance.	

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F 244	Continued From page 18 go to bingo on Saturday or mass on Sundays. We would like more movies. It's a real problem they have and they don't understand how importance this is to us. This is our home and we have to live here." C. Review of the November 2013 Activity Schedule indicated no activities were scheduled during the week after 3:00 pm. It further indicated that there are no activities scheduled on the weekend after 2:00 pm. Scheduled activities on the weekend included "Bingo, Bible Study, or TV Time." D. On 11/14/13 at 2:00 pm, during observation there were no residents identified in the assistive dining room participating in the scheduled activity at 2:00 pm which was "Bible Study". At 2:30 pm the scheduled activity was "Pet Visit" and at 3:00 pm the scheduled activity was "Piano Sing-Along" in the main dining room. There were no activities observed with any residents during these scheduled times. E. On 11/15/13 at 3:00 pm, during interview, regarding the activities for nights and weekends, the Activities Manager stated, "I'm having trouble getting volunteers in from the community. We hardly have anything in the evenings. At most a church group comes in and a few other people. I did inform the residents that starting in January 2014, we will not have a budget for activities. I will have to do my own fundraising out in the community. The residents are always asking me for more movies and popcorn in the evenings but we haven't done that yet, the reason is because I haven't had someone to help me out in that area. I just don't have time. On Sundays, I don't have anything on Sunday mornings. When I have	F 244		

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F 244	Continued From page 19 brought up concerns to the Administration they tell me the census has to go up. But they do know I need a lot of help in activities. I haven't had a chance to present this meeting to the Administrator yet because I have been so busy." Regarding the activities that were scheduled for 11/14/13 (Bible Study, Pet Visit, and Piano Sing Along) she stated, "With the activities that were scheduled yesterday (11/14/13) they got cancelled."	F 244		
F 246 SS=E	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. This REQUIREMENT is not met as evidenced by: Based on observation and interviews the facility failed to ensure that the pull cord for the emergency call light was long enough for residents to access and pull for help in seven (7) rooms (Room #s 9, 10, 11, 12, 23, 25 and 47) of fifty one (51) rooms in the facility. The pull cords were either attached to a hook on the wall or tied to the hand rail. This failed practice could result in residents not being able to call for help if they should fall to the floor while in the bathroom. The findings are: A. On 11/19/13 during observation of the residents bathrooms, the emergency call lights	F 246	F 246 Bathroom call cords for residents #9, 10, 11, 12, 23, 25, and 47 have been placed within reach. An audit of bathroom call cords will be completed to ensure call cords are within resident reach. Facility staff will be in-serviced on proper location of bathroom call cords. The mock survey team will audit location of bathroom call cords during mock survey rounds 5x weekly and report results to the ED. The results of the audit will be reported to the monthly QAPI committee to ensure substantial compliance.	12/30/2013

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F 246	Continued From page 20 pull cords in rooms #s 9, 10, 11, 12, 23, 25 and 47 were either attached to a hook on the wall or tied to the hand rail making it impossible for residents to reach them and call for help if they should fall to the floor. B. On 11/19/13 Interviews revealed the following: 1. At 2:30 pm, Director of Maintenance confirmed that the call light cord was too high to be reached from the floor. He stated "The cord should be accessible from the toilet and the floor. Someone on the floor wouldn't be able to reach that." (referring to the cord) 2. At 2:45 pm, House Keeping/Laundry Supervisor stated "That is a problem. My staff came to me with this complaint [cords attached to hook on wall or tied to hand rail]. If they [residents] fall, they need to be able to reach the call light [cord]. I've mentioned it to the nurses months ago and it continues to happen." 3. At 3:00 pm, Certified Nursing Assistant #1 (CNA) stated, "We tie it [cord] to the rail because it keeps them [residents] from leaning too far forward and falling." 4. At 3:10 pm, The Director of Nursing (DON) stated "This is common practice around here [for call light cords to be attached to rail or wall] so they can reach it from the commode but if someone fell they wouldn't be able to reach it." 5. At 3:45 pm, CNA #2 stated, "The call bell [cord] is attached to the rail so the residents can call if they need help but they won't be able to reach it from the floor." 6. At 3:50 pm, CNA #3 stated, "They [residents] need to be able reach it [cord] from the commode to call for help. They cannot reach it from the floor."	F 246		

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F 248	Continued From page 21	F 248		
F 248 SS=E	483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to provide an ongoing activity program, particularly for evening and weekend hours, to enhance the resident's highest practicable level of well being for four (#7, 20, 72, and 85) residents in the facility. This deficient practice has the potential to result in the loss of mental, physical, and social well being. The findings are: A. Review of the November 2013 Activity Schedule indicated no activities scheduled during the week after 3:00 pm. It further indicated that there are no activities scheduled on the weekend after 2:00 pm. Scheduled activities included "Bingo, Bible Study, or TV Time". B. Observations indicated the following in which no activities were taking place: 1. On 11/12/13 at 2:30 pm, no activities were taking place in the facility. 2. On 11/13/13 at 2:00 pm, the scheduled Bingo activity was not occurring. 3. On 11/12/13-11/19/13, no activities occurred after 3:00 pm and no activities were scheduled according to the Activity Calander.	F 248	F 248 Resident's # 7, 20, 72, and 85 activity profile will be reassessed to ensure activity preferences are addressed. The current activity program calendar will be reviewed to ensure programs are offered during evenings and weekends to meet their needs and interest. Facility staff will be in-serviced to inform and assist residents to daily activities of their choice. The ED/designee will randomly audit the active calendar to ensure evening and weekend programs are offered 2 x weekly x 4 weeks, then monthly x2 months. The results of the audit will be reported to the monthly QAPI committee to ensure substantial compliance.	12/30/2013

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F 248	Continued From page 22 C. Record Review and interviews for Resident #7's revealed the following: 1. Care Plan notes (not dated) indicated that the resident actively participates in many activities. 2. Activities Assessment (no dated) further indicated her many skills and interests and the activity log notes good participation. 3. On 11/13/13 at 2:00 pm, during interview Resident R #7 stated, "We've been dealing with a lot lately. I'm having to try to come up with programs for us [referring to the residents) to do such as the Christmas dinner. For example, with our Resident Council meeting we had yesterday (11/12/13), with the activities, everyone was angry because of the activity budget for 2014. We were told that beginning in January we will no longer have money for activities. They took activities away from us, but yet they can pay for a newsletter and a calender. Our activities program is very poor. It's the evenings and weekends that is a problem especially on Saturdays. We just have Bingo on Saturdays and Sunday we have mass and that is it. I think we need something more in case a person doesn't want to go to bingo on Saturday or mass on Sundays. We would like more movies. It's a real problem they have and they don't understand how importance this is to us. This is our home and we have to live here." D. Record review and interviews for Resident R #85 revealed the following information: 1. Activity Log (no date) indicated TV is the primary activity the resident is involved in. 2. On 11/13/13 at 8:43 am, during interview, R #85 was asked if there are activities provided as often as you would like including on the weekends and evenings and he stated, "No, there	F 248		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PALOMA BLANCA HEALTH AND REHABILITATION	1509 UNIVERSITY BOULEVARD NE ALBUQUERQUE, NM 87102

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F 248	Continued From page 23	F 248		

are not many activities in the evening or the weekends. During the week, they announce there will be activities, but there is nothing on the weekend or in the evening times."

E. On 11/14/13 at 2:00 pm, observation revealed there were no residents identified in the assistive dining room participating in the scheduled activity at 2:00 pm which was "Bible Study". At 2:30 pm the scheduled activity was "Pet Visit" and at 3:00 pm the scheduled activity was "Piano Sing-Along" in the main dining room. There was no activities observed occurring with any residents during these scheduled times.

F. On 11/15/13 at 3:00 pm, during interview, regarding the activities for nights and weekends, the Activities Manager stated, "I'm having trouble getting volunteers in from the community. We hardly have anything in the evenings. I don't hardly have anything in the evenings. At most a church group comes in and a few other people at the lowest cost that we have. That way we don't have to spend a lot of money. I did inform the residents that starting in January 2014, we will not have a budget for activities. I will have to do my own fundraising out in the community. The residents are always asking me for more movies and popcorn in the evenings but we haven't done that yet. The reason is because I haven't had someone to help me out in that area. I just don't have time. Between the meetings I have in the mornings and afternoon and care plans, I really don't have times. On Sundays, I don't have anything on Sunday mornings. When I have brought up concerns to the Administration they tell me the census has to go up. But they do know I need a lot of help in activities. I haven't had a chance to present this meeting to the

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F 248	Continued From page 24 Administrator yet because I have been so busy,". Regarding the scheduled activities that were scheduled for 11/14/13 (Bible Study, Pet Visit, and Piano Sing Along) she stated, "With the activities that were scheduled yesterday (11/14/13) they got cancelled. We were supposed to have a pet visit and a Bible study. I didn't have time yesterday." She then indicated, "With regards to [name of R #85], he doesn't participate. Whenever I have offered him activities, he just says no not interested." G. On 11/13/13 at 3:17 pm, during interview with Resident #20, she stated that activities are no longer provided at night and that "not much goes on during the weekend." She stated that the only activities that are available on the weekend are Bingo and Bible Study. She also mentioned that during the Resident Council Meeting on 11/11/13, the residents were told by the Activities Manager that residents would have to start donating money to the Activity Fund as the program was losing funding from the Corporate Office. H. On 11/14/13 at 2:57 pm, during a family interview for Resident #72, the family member stated that the resident was asked if he participated in activities but the resident stated that nobody gets him up for activities.	F 248		
F 280 SS=E	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.	F 280	F 280 1. Resident #'s 58, 22, 39, 122, 153, 64, 29, 71, 181, 126, 32, 117, & 145 no longer reside at the facility. The remaining resident's care conferences are scheduled and include invitations to residents and / or RP.	12/30/2013

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F 280	Continued From page 25 A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to ensure that residents and/or family members have the right to participate in planning of care, treatment, or change of care for two (#71, #72, and) of thirty-three residents (#s 2, 3, 7, 20, 22, 29, 32, 34, 37, 38, 39, 41, 52, 58, 64, 71, 72, 85, 93, 102, 104, 109, 117, 121, 122, 126, 140, 145, 153, 168, 171, 173 and 181). This deficient practice has the potential to prevent residents and/or family members from being fully informed of the resident's care goals, and may affect decision making regarding care. The findings are: A. A review of Resident #71's Care Conference sign-in sheet indicated that family members were not present for care plan conferences conducted on 05/08/13, 08/07/13, and 10/30/13. B. On 11/13/13 at 9:52 am during interview with Resident #71's family member, he stated that "I	F 280	An audit of current residents will be completed to ensure residents are notified of care conference date and care conference letters are sent to RP. The Social Service Director will develop and implement a process to ensure notification of resident care conferences. The IDT will be in-serviced on the policy / procedure for scheduling and notification of resident care conferences. The ED/designee will randomly audit care conference schedule to ensure notification to RP has occurred weekly x 4 weeks, then monthly x 2 months. Results of the audit will be reported to the monthly QAPI committee to ensure substantial compliance.	

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have had some concerns regarding this [care plan meetings]. In the past, they notified me when things were being changed, for example, her medications. I have specifically asked to be notified when anything is being changed, especially her medications and have found that this has fallen by the wayside."

C. On 11/19/13 at 2:46 pm during interview with the District Director of MDS (Minimum Data Set) she stated that when she was at the facility in the beginning of November 2013, it was identified that there was a problem getting care conference letters out. It was identified that at least 3 weeks were missing. The facility has not started the audit on Care Conference Letters but is aiming to be in compliance by December 15, 2013 and to be sending Care Conference Notification Letters to family members/responsible parties on a regular basis. For Resident #71, she was unable to locate any care conference notification letters. She stated that these letters are initiated in the Social Services Department and filed in a notebook in this department as well.

D. On 11/19/13 at 3:00 pm during interview with the Social Services Director, she stated that the Social Services Department is responsible for sending the Care Conference Notification letters to family members/responsible parties and copies of the letters are then filed in a notebook which is kept in the Social Services Office. She was unable to locate any Care Conference Notification letters for Resident #71.

E. On 11/15/13 at 1:15 pm, during an interview

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F 280	Continued From page 27 with the Social Services Director, she stated that a letter is sent to family members, and a copy given to residents, informing them of and inviting them to, care plan meetings. When asked about Resident #72's care plan meeting, she stated that this was an "off-schedule" care plan meeting, as they were behind schedule for updating care plans, so no family was invited. F. A review of the Care plan conference record indicated that care plan conferences were held on 08/03/13 and 10/30/13. There was no documentation to indicate that family members had participated. G. On 11/15/13 at 4:00 pm during an interview with the Director of Social Services, she stated that she was unable to find them. Her memory is that the family was invited, but that the family refused to come. She stated that she only began working at the facility in late July, and had not assumed responsibility for writing the letters in time for the 08/03/13 care plan conference. She stated that the later care plan conference for this resident, held on 10/30/13, was an emergency conference because they had fallen so far behind in care planning, and families were not invited during this period. She was able to produce copies of letters both prior to and after this period that had gone out to other families.	F 280		
F 282 SS=G	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.	F 282	F 282 C.N.A #1 is no longer employed by the facility.	12/30/2013

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F 282	Continued From page 28 This REQUIREMENT is not met as evidenced by: Based on record review and interviews, the facility failed to follow 1 (R #6) of 1 (R #6) physician's comprehensive plan of care which resulted in the resident being transferred from the bed to a wheelchair by use of a Hoyer lift (an assistive device that allows patients to be transferred between a bed and a chair) with only one person instead of two (as was indicated to use two persons in the care plan). This deficient practice likely caused the resident to fall backwards in her wheelchair hitting her head and sustaining a hematoma (swelling with containing blood), bruising and a contusion (an injury caused by a blow to the body characterized by swelling, discoloration and pain) to the back of the head. The findings are: A. Record review and interviews for Resident R #6 revealed the following information: 1. Comprehensive Plan of Care dated 10/17/12 indicated the resident has a self-care deficit with lower extremity activities of daily living (ADLs) related to a diagnosis of paraplegia (paralysis in the lower limbs and trunk of the body). Interventions are for staff to use a Hoyer lift with two people for transfers. The Care Plan also indicated the resident is at risk for falls related to a history of falls and staff is to again use two persons for transfers with a Hoyer lift. 2. Annual Minimum Data Set (MDS) dated 03/31/13 indicated, the resident requires two + persons physical assistance for transfers and bed mobility. 3. Annual History and Physical Examination dated 07/25/13 indicated the resident has medical diagnoses to include paraplegia, spinal stenosis	F 282	An audit of current resident's transfer/mobility status will be conducted. The resident's care plan and kardex will be updated to accurately reflect transfer/mobility status. Nursing staff will be re-educated to ensure competency when transferring residents using a mechanical lift. The DCS/designee will randomly observe resident transfers to ensure staff of following the resident's plan of care 5 x weekly x 4 weeks, then 2 x weekly x 3 months. Results the audit will be reported to the monthly QAPI committee to ensure the facility remains in substantial compliance.	

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(an abnormal narrowing of the spinal cord) and Cerebrovascular Accident (CVA).
4. Nurse's Notes dated 09/23/13 indicated, "Pt. [patient] fell backwards in her wheelchair this morning when Certified Nursing Assistant (CNA) [who was identified as CNA #1] lifted patients legs. Patient hit the occipital region (area of the back of the head) that resulted in a hematoma. Patient reports mild pain at the site of the hematoma. Examination was positive for hematoma and contusion.

5. Root Cause Analysis for fall dated 09/23/13 indicated, "Were appropriate number of assists used? No ...Was proper technique used? No ...Did resident sustain injury? Yes. What was the injury ...Swelling to back of head."
6. On 09/27/13 at 11:00 am, during interview R #6 stated, "All I know is that I fell off the wheelchair and was picked up off the floor and I have a big knot on my head now. From what I remember, one man was helping me from the bed to my wheelchair. He was using a Hoyer lift to lift me. When this happened, he was the only aide who got me out of bed and put me in the wheelchair and I fell straight back onto my head."

7. On 09/27/13 at 11:05 am, during interview CNA #1 stated, "I was transferring [name of R #6] with the Hoyer lift into her wheelchair and when she got into her w/c she was slipping forward. I was transferring her from the bed to the wheelchair by myself. She was very heavy and we need a lot of help to get her up. As she was trying to help me push herself up in the w/c, I was pushing her legs and she fell straight back in her w/c and hit her head on the floor. I knew I needed two people to transfer her from the bed to her w/c. I was supposed to be using two people assist with the Hoyer lift. The problem was I was busy getting people up for breakfast. I knew it

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was my fault and I know it was our policy to always use two people to transfer her in the Hoyer lift."

8. On 09/27/13 at 11:45 am, during interview Licensed practical Nurse (LPN) #1 stated, "I was getting report from the night nurse and the CNA [identified as CNA #1] told me [name of R #6] was on the floor. So I went in her room and the w/c was on its back and she was lying right next to it on her back. The CNA told me he was lifting the resident into the w/c with the Hoyer lift by himself and he was trying to pull her up in the wheelchair and the wheelchair tipped over and she fell out. She [referring to R #6] did tell me that she hit her head. She did have a knot at the base of her neck. After that we got neuro-checks and she went to breakfast."

9. On 09/27/13 at 12:00 noon, during interview the Director of Nursing (DON) stated that the resident [referring to R #6] requires maximum assistance to get to her bed and to the toilet and back to her wheelchair. She further indicated that she does require the use of two persons when using the Hoyer lift.

10. On 09/27/13 at 12:20 pm, during interview the Corporate Clinical Ambassador stated, "We even had an inservice on mobility transfers back in February of this year and that CNA [referring to CNA #1] did attend and he should have known better than to do this. I'm not happy about this right now."

11. On 09/27/13 at 1:40 pm, during interview the Administrator stated, that in this case the care plan was not being followed and there was harm done to the patient ... "In my opinion, there was neglect to follow the plan of care and neglect to follow our own policy."

12. On 09/27/13 at 2:00 pm, during interview, CNA #2 stated, "She [referring to R #6] was on

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F 282	Continued From page 31 the ground when I walked in. I saw the wheelchair on its back and she was laying on it. I have worked with her before and normally we are supposed to have two people for every lift that we are doing. There always has to be two people." B. Review of the facility's Policy and Procedure regarding Hoyer Lifts revised 01/03/13 indicated, "The Hoyer Lift is used for residents who do not bear weight or walk; or those residents who may be too heavy for you to transfer safely ...Hoyer Lift is a 2 person assist transfer."	F 282		
F 285 SS=D	483.20(m), 483.20(e) PASRR REQUIREMENTS FOR MI & MR A facility must coordinate assessments with the pre-admission screening and resident review program under Medicaid in part 483, subpart C to the maximum extent practicable to avoid duplicative testing and effort. A nursing facility must not admit, on or after January 1, 1989, any new residents with: (i) Mental illness as defined in paragraph (m)(2)(i) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission; (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services for mental retardation. (ii) Mental retardation, as defined in paragraph (m)(2)(ii) of this section, unless the State mental	F 285	F 285 Resident #2's PASRR screen has been completed. An audit of residents admitted in the past 3 months will be conducted to ensure PASRR screens have been completed according to Medicaid regulations. Facility staff responsible for pre-admission screening (PASRR) will be re-inserviced to ensure regulatory compliance.	12/30/2013

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F 285	Continued From page 32 retardation or developmental disability authority has determined prior to admission-- (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services for mental retardation. For purposes of this section: (i) An individual is considered to have "mental illness" if the individual has a serious mental illness defined at §483.102(b)(1). (ii) An individual is considered to be "mentally retarded" if the individual is mentally retarded as defined in §483.102(b)(3) or is a person with a related condition as described in 42 CFR 1009. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to complete a Pre-Admission Screening and Resident Review (PASRR) Level 1 Identification Screen prior to admitting 1 (R #2) of 1 (R #2) residents to the nursing facility due to a diagnosis of a history of Depression and Anxiety. This deficient practice likely resulted in R #2 being admitted to the skilled nursing facility without a proper screening being conducted which could have resulted in the resident not being able to receive services as required in a skilled nursing facility. The findings are: A. Record review and interviews for R #2 revealed the following information: 1. Face Sheet dated 07/08/13 indicated that the resident was admitted to the facility on	F 285	The ED/designee will audit admissions to ensure PASRR screening is completed 5x weekly x 4 weeks, then monthly thereafter. Results to the audit will be reported to the monthly QAPI committee to ensure facility remains in substantial compliance.	

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F 285	Continued From page 33 05/28/13. Admitting diagnosis included Anxiety state. 2. PASRR Level 1 identification screening form dated 05/24/13 (from the transferring facility) indicated "yes" that the resident does have a diagnosed or suspected mental illness other than dementia; "yes" due to the mental illness, within the past 6 months has the person had difficulties with a) interpersonal functioning (for example, fights, evictions, fear of strangers, social isolation); or b) Concentration, persistence, or pace; or c) adaptation to change, and "yes" due to the mental illness, within the past two years has the person had more than one inpatient or partial psychiatric hospitalization. The PASRR screening form further indicated that if all items are answered yes, the person must be referred to PASRR prior to admission. 3. Psychiatry Consultation report (from the previous facility) dated 04/23/13 indicated that the resident had been being seen by psychiatry, also had a past medical history of Depression, and Borderline Personality Disorder. 4. On 09/26/13 at 3:00 pm, during interview Social Worker #1 stated, "She [referring to R #2] was admitted to the facility on 05/28/13 without getting a PASRR screening. We require that every person have a Level 1 screening completed prior to admission and she was admitted before the evaluation was done." 5. On 09/26/13 at 4:00 pm, during interview, the Administrator stated, "Our policy is that a PASRR Level I should always be completed prior to admission into our building." 6. On 09/30/13 at 10:15 am, during interview Social Worker #2 (Social Worker from the PASRR Screening Program) stated, "On June 24, we received a PASRR level I screening form saying that [name of R #2] had already been	F 285		

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F 285	Continued From page 34 admitted to [name of nursing facility] back on May 28, 2013. This issue was that she had already been admitted to the nursing home a month before we were even able to do the screening on her. She had been admitted to the nursing facility on 05/28/13 prior to the PASRR program ever being notified. Everybody going into a nursing facility has to have a Level I screen completed prior to admission if they meet the criteria on the form for a mental illness or mental retardation. A determination has to be done prior to being admitted to the nursing facility and it was not done in this case." 7. On 10/01/13 at 8:30 am, during interview a Staff Manager with the PASRR program stated, "It looks like the resident was admitted to the nursing home without having the PASRR screening done. She was admitted on 05/28/13 and she should have been assessed by PASRR before. It looks like that nursing home did admit [name of R #2] without proper PASRR review and determination. There was supposed to be a Level I screen for every person suspected of a mental illness and this was not done." B. Review of the facility's PASRR Policy (no date) indicated, "Pre-admission assessments by PASRR must be completed BEFORE the individual's entrance into the nursing facility."	F 285		
F 323 SS=G	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.	F 323	F 323 Resident #6 is transferred using a mechanical lift with 2-person assist.	12/30/2013

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	325060	A. BUILDING _____ B. WING _____	C 11/19/2013

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PALOMA BLANCA HEALTH AND REHABILITATION	1509 UNIVERSITY BOULEVARD NE ALBUQUERQUE, NM 87102

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F 323	Continued From page 35 This REQUIREMENT is not met as evidenced by: Based on record review and interviews, the facility failed to ensure 1 (R #6) of 1 (R #6) residents received adequate supervision and assistance to prevent an accident in which the resident was being transferred from the bed to a wheelchair by use of a Hoyer lift (an assistive device that allows patients to be transferred between a bed and a chair) with only one person instead of the required two. This deficient practice likely caused the resident to fall backwards in her wheelchair hitting her head and sustaining a hematoma (swelling with containing blood), contusion (an injury caused by a blow to the body characterized by swelling, discoloration and pain) and bruising to the back of the head. The findings are: A. Record review and interviews for R #6 revealed the following information: 1. Comprehensive Plan of Care dated 10/17/12 indicated the resident has a self-care deficit with lower extremity activities of daily living (ADLs) related to a diagnosis of paraplegia (paralysis in the lower limbs and trunk of the body). Interventions are for staff to use a Hoyer lift with two people for transfers. The Care Plan also indicated the resident is at risk for falls related to a history of falls and staff is to again use two persons for transfers with a Hoyer lift. 2. Annual Minimum Data Set (MDS) dated 03/31/13 indicated, the resident requires two + persons physical assistance for transfers and bed mobility. 3. Annual History and Physical Examination dated 07/25/13 indicated the resident had	F 323	Current residents transferred using a mechanical lift will have a new transfer/mobility assessment completed to ensure appropriate transfer status. Nursing staff will be re-inserviced regarding low lift policy to include number of staff needed when using a mechanical lift. DCS/designee will conduct random observation audits of residents transfers using a mechanical lift 5 x weekly x 4 weeks, then 2 x weekly x 3 months to ensure resident's are transferred per policy. Results of the audit will be reported to the monthly QAPI committed to ensure facility remains in substantial compliance.	

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F 323	Continued From page 36	F 323		

medical diagnoses to include paraplegia (paralysis in the lower limbs and trunk of the body), spinal stenosis (an abnormal narrowing of the spinal cord) and who sustained a Cerebrovascular Accident (CVA).

4. Nurse's Notes dated 09/23/13 indicated, "Pt. [patient] fell backwards in her wheelchair this morning when Certified Nursing Assistant (CNA) [who was identified as CNA #1] lifted patients legs. Patient hit the occipital region (area of the back of the head) that resulted in a hematoma. Patient reports mild pain at the site of the hematoma. Examination was positive for hematoma and contusion."

5. On 09/27/13 at 11:00 am, during interview R #6 stated, "All I know is that I fell off the wheelchair and was picked up off the floor and I have a big knot on my head now. From what I remember, one man was helping me from the bed to my wheelchair. He was using a Hoyer to lift me. When this happened, he was the only aide who got me out of bed and put me in the wheelchair and I fell straight back onto my head."

6. On 09/27/13 at 11:05 am, during interview CNA #1 stated, "I was transferring [name of R #6] with the Hoyer lift into her wheelchair and when she got into her w/c she was slipping forward. I was transferring her from the bed to the wheelchair by myself. She was very heavy and we need a lot of help to get her up. As she was trying to help me push herself up in the w/c, I was pushing her legs and she fell straight back in her w/c and hit her head on the floor. I knew we needed two people to transfer her from the bed to her w/c. We were supposed to be using two people assist with the Hoyer lift. The problem was I was busy getting people up for breakfast. I knew it was my fault and I know it was our policy to always use two people to transfer her in the

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F 323	Continued From page 37 Hoyer lift." 7. On 09/27/13 at 11:45 am, during interview Licensed practical Nurse (LPN) #1 stated, "I was getting report from the night nurse and the CNA [referring to CNA #1] told me [name of R #6] was on the floor. So I went in her room and the w/c was on its back and she was lying right next to it on her back. The CNA [referring to CNA #1] told me he was lifting the resident into the w/c with the Hoyer lift and he was trying to pull her up in the wheelchair and the wheelchair tipped over and she fell out. She did tell me that she hit her head. She did have a knot at the base of her neck. After that she went to breakfast." 8. On 09/27/13 at 1:40 pm, during interview the Administrator stated, "In this case, our care plan was not being followed and there was harm done to the patient...In my opinion, there was neglect to follow the plan of care and neglect to follow our own policy...and the resident [referring to R #6] did sustain actual harm." 9. On 09/27/13 at 2:00 pm, during interview, CNA #2 stated, "She [referring to R #6] was on the ground when I walked in. I saw the wheelchair on its back and she was laying on it. I have worked with her before and normally we are supposed to have two people for every lift that we are doing. There always has to be two people." B. Review of the facility's Hoyer Lift Policy and Transfers Policy revealed the following information: 1. Hoyer Lift Policy dated 01/03/13 indicated, "Hoyer Lift is a 2 person assist transfer." 2. Transfers Policy revised on 09/01/2011 indicated, "Purpose is to enable the resident to transfer safely...Follow specific orders as to type of transfer to be performed."	F 323		

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F 431	Continued From page 38	F 431		
F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by:	F 431	F 431 No medications were diverted or missing and no residents were affected. The medication box used to store schedule II control substances was "affixed" to the refrigerator on 11/14/13. The facility administrative team has been in-serviced on storage of schedule II medications. The DCS/designee will randomly audit schedule II medications to ensure proper storage weekly x 4 weeks, then monthly x 2 months. Result the audit will be reported to the monthly QAPI committee to ensure substantial compliance.	12/30/2013

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F 431	Continued From page 39 Based on observations and interviews, the facility failed to ensure that the box used to store Schedule II controlled medications was secured and a permanently affixed compartment available only to designated staff. The box not being permanently affixed to the refrigerator could likely cause medications to be diverted or misplaced from the medication room negatively, potentially making them available to the residents. This deficient practice presents a risk of potential harm to 35 residents on the north hall (identified on the Census List provided by the Administrator on 11/12/13). The findings are: A. On 11/14/13 at 2:00 pm, observation of the medication room refrigerator on the north hall revealed a Schedule II controlled medication narcotic lock box which was not permanently affixed or secured to the refrigerator. The box contained 3 Dronabinol 5 mg soft gels. (A Schedule III drug). B. Interviews revealed the following: 1. On 11/14/13 at 2:20 pm, Registered Nurse #1 (RN) stated that all narcotics that needs to be refrigerated are kept in the same black box that was located in the refrigerator. "I was not aware that the box needed to be affixed to the refrigerator." 2. On 11/14/13 at 2:30 pm, License Practical Nurse #1 (LPN) confirmed that the black box was not affixed to the refrigerator and that it contained 3 Dronabinol (Marinol) 5 mg (milligrams) soft gels. When asked, "What is your understanding of how refrigerated controlled substances should be stored?" LPN #2 stated, "They have to be under two locks. One on the door and one on the refrigerator. I didn't know the box had to be affixed." (to the refrigerator). 3. On 11/14/13 at 3:10 pm, the Director of	F 431		

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F 431	Continued From page 40 Nursing (DON) confirmed that the black box was not affixed to the refrigerator and stated "Narcotics should be double locked and the box should be affixed to the refrigerator." 4. On 11/15/13 at 12:45 pm, the Regional Nurse Consultant implied that it was not necessary for the box to be affixed to the refrigerator by stating "The box has to be affixed only if it contains a Schedule II drug...Marinol is a Schedule III."	F 431		
F 520 SS=F	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.	F 520	F 520 Quality Assurance / Performance Improvement (QAPI) committee will meet monthly. A monthly QAPI committee meeting schedule will be established to include the Interdisciplinary Team and Medical Director. The ED has been in-serviced on the expectation to conduct monthly QAPI committee meetings The RVPO/RDCS will audit QAPI meeting minutes to ensure the committee meets monthly to address pertinent agenda items monthly x 3 months.	12/30/2013

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F 520	Continued From page 41 This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure that the quarterly quality assurance [QA] meetings had Medical Director representation since March 2013. This failed practice could result in quality issues not being communicated and continuity of care addressed which presents a risk of potential harm to 107 residents per alphabetical list provided by the Administrator on 11/12/13. The findings are: A. On 11/19/13 during review of the Quality Assessment Meeting sign in sheets for the first three quarters of 2013 the following was noted: 1. During the first quarter ending March 2013, there was no signature by the medical director. 2. During review of the second quarter ending June 2013, there was no information at all indicating they had any QA meetings or that the medical director attended. 3. During review of the third quarter ending September 2013, there was no signature by the medical director. There was no documentation that a QA meeting was held in September 2013. B. On 11/19/13 at 4:30 pm during interview with the Administrator, she stated that she did not want to comment on whether the medical director had attended QA meetings during the quarters prior to her employment.	F 520		