STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	325036	A. BUILDING _____ B. WING _____	12/30/2016

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
LAS PALOMAS CENTER	8100 PALOMAS AVENUE ALBUQUERQUE, NM 87109

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0223 **Level of harm** - Actual harm **Residents Affected** - Few	**Protect each resident from all abuse, physical punishment, and being separated from others.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure that residents were free from alleged sexual abuse for 1 (R #1) of 4 (R #1, 2, 3, 4) residents reviewed for abuse. This deficient practice resulted in R #1 experiencing feelings of anxiety, fear, discomfort and led to her having nightmares. The findings are: A. On 12/30/16 at 8:22 am, during an interview with the PTA (physical therapy assistant), she stated that R #1 came to therapy and told her that something strange happened. R #1 told PTA that on 09/12/16 she woke up to CNA #1 (certified nursing assistant) massaging her. PTA stated that R #1 told her that she woke up and CNA #1 was sitting on her bed and rubbing her. PTA also stated that R #1 was very concerned when telling her what happened. B. On 12/30/16 at 8:31 am, during an interview with the DON (Director of Nursing), she stated that R #1 told her that there was not penile penetration, but that CNA #1 did put his hand in R #1's vagina. The DON stated that after R #1 disclosed this to her she (R #1) did agree to get a SANE (Sexual Assault Nursing Exam). C. On 12/30/16 at 10:10 am, during an interview with the SSD (social services director) she stated that she was the first person to interview R #1 regarding the alleged abuse. The SSD stated that R #1 informed her that the encounter took place after she (R #1) went to bed and lasted around thirty minutes. The SSD also stated that R #1 wasn't able to pinpoint the exact time of the alleged abuse because it was very dark in the room at that time. R #1 told SSD #1 that CNA #1 was going to massage her leg and she told him that is not my leg. D. On 12/30/16 at 10:45 am, during an interview with CNA #1, he stated that he was called in by the Administrator and the Administrator told him that there was a complaint filed against him alleging that he touched one of the residents inappropriately and he was being suspended. CNA #1 stated that he didn't know who said these things about him. He stated that he was currently still suspended from going back to work. CNA #1 stated that he had not ever given a resident a massage. When asked again, CNA #1 then stated that he had given one resident a neck massage and that this resident was very independent and he had given this resident a neck massage in front of everyone. E. On 12/30/16 at 1:58 pm, during an interview with R #1, she stated that CNA #1 had come into her room about one month prior and had told her that he would massage her leg because he knew it had been hurting. She stated that he told her that his wife lived in Mexico and also told her don't worry, don't worry my wife is a white woman. She stated that she didn't understand or know why he had told her that. She thought it was odd. R #1 stated that she woke up and CNA #1 was massaging her. She stated that she didn't have a roommate at that time. She stated that she was unsure of the exact time, but that she had the TV on because the TV helps her fall asleep at night and that the curtain was drawn and it was dark, but she thought that this happened between 9:00 pm and 10:00 pm. R #1 also stated that she saw CNA #1 the next day and he told her that he would see her tonight. She stated that she just didn't feel right about it and it wasn't ok, so she told the PTA. R #1 also stated that Massaging my leg is one thing and probing my crotch is another. She also stated that she started having nightmares a couple of weeks ago. She stated. that another thing about rape and incest is you let them do it and then you get out alive. At 62, I'm not a sexy person so I'm not sure why he did that or why he chose me. She indicated that she had a good rapport with CNA #1 before the incident happened with him and that after the incident and after she told everyone, she withdrew and became more depressed. G. On 01/03/16 at 10:45 am, during a phone interview with the Registered Nurse (RN) who performed the SANE exam, she stated that R #1 arrived in her wheelchair and notified her (nurse) that she (R #1) had some right sided weakness. The SANE Nurse stated that R #1 told her that she was digitally (by hand) penetrated by CNA #1. The SANE Nurse stated that anytime there is bruising on the cervix, it is caused by internal friction or trauma. She stated that the specific bruising on R #1's cervix, in her professional experience, appeared like it could have been caused by a fingernail. She also stated that there has to be penetration and trauma to the cervix to create a bruise. She stated that R #1 told her that she was unable to use her call light/call button, because the button was on the right side of the bed, she was unable to get it and she was scared. R #1 told the SANE nurse that she (R #1) was concerned about the [AGE] year old resident's and didn't want this happen to one of them. H. On 01/11/17 at 10:45 am, during an interview with the Violent Crimes Detective, she stated that when she interviewed R #1 she was clear, consistent and detailed. She stated that her investigation was ongoing at that time. I. Record review of R #1's medical record indicated that on the night of 09/12/16, the day of the alleged abuse, R #1 did not have a roommate. J. Record review of the investigative report dated 09/12/16 indicated that CNA #1 worked the night of 09/12/16. He clocked in at 1:55 pm and clocked out for dinner at 9:11 pm, clocked back in at 9:40 pm and clocked out for the evening at 10:10 pm. R #1 stated that she thought the incident occurred between 9 pm and 10 pm. K. Record review of the SANE report written and filled out by the SANE RN indicated that her findings were: 1. Redness at urethral meatus (opening of the urethra) noted and tenderness to touch. 2. Redness to cervix and tenderness to touch surrounding cervix. 3. Red/bruise yellow/brown to cervix at 6 1/2 o'clock. Note: white/cream discharge noted on cervix, collected with cervical swabs.
F 0226 **Level of harm** - Actual harm **Residents Affected** - Few	**Develop policies that prevent mistreatment, neglect, or abuse of residents or theft of resident property.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to implement policies and procedures to prevent abuse for 1 (R #1) of 4 (R #s 1, 2, 3 and 4) residents reviewed for abuse. This deficient practice resulted in R #1 experiencing of feelings of anxiety, fear, discomfort and led to her having nightmares. The findings are: A. On 12/30/16 at 8:22 am, during an interview with PTA (physical therapy assistant), she stated that R #1 came to therapy and told her that something strange happened. R #1 told PTA that on 09/12/16 she woke up to CNA #1 (certified nursing assistant) massaging her. PTA stated that R #1 told her that she woke up and CNA #1 was sitting on her bed and rubbing her. PTA also stated that R #1 was very concerned when telling her what happened. B. On 12/30/16 at 8:31 am, during an interview with DON (Director of Nursing), she stated that R #1 told her that there was not penile penetration but that CNA #1 did put his hand in R #1's vagina. The DON stated that after R #1 disclosed this to

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

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 0226 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 1) her she (R #1) did agree to get a SANE (Sexual Assault Nursing Exam). C. On 12/30/16 at 10:10 am, during an interview with SSD (social services director) she stated that she was the first person to interview R #1 regarding the alleged abuse. The SSD stated that R #1 informed her that the encounter took place after she (R #1) went to bed and lasted around thirty minutes. The SSD also stated that R #1 wasn't able to pinpoint the exact time of the alleged abuse because it was very dark in the room at that time. R #1 told SSD #1 that CNA #1 was going to massage her leg and she told him that is not my leg. D. On 12/30/16 at 10:45 am, during an interview with CNA #1, he stated that he was called in by the 4 Administrator and the Administrator told him that there was a complaint filed against him alleging that he touched one of the residents inappropriately and he was being suspended. 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On 01/11/17 at 10:45 am, during an interview with the Violent Crimes Detective, she stated that when she interviewed R #1 she was clear, consistent and detailed. She stated that her investigation was ongoing at that time. Record review of R #1's medical record indicated that on the night of 09/12/16, the day of the alleged abuse, R #1 did not have a roommate. J. Record review of the investigative report dated 09/12/16 indicated that CNA #1 worked the night of 09/12/16. He clocked in at 1:55 pm and clocked out for dinner at 9:11 pm, clocked back in at 9:40 pm and clocked out for the evening at 10:10 pm. R #1 stated that she thought the incident occurred between 9 pm and 10 pm. K. Record review of the SANE report written and filled out by the SANE RN indicated that her findings were: 1. Redness at urethral meatus (opening of the urethra) noted and tenderness to touch. 2. Redness to cervix and tenderness to touch surrounding cervix. 3. Red/bruise yellow/brown to cervix at 6 1/2 o'clock. Note: white/cream discharge noted on cervix, collected with cervical swabs. L. Record Review of the facility's Abuse Prohibition Policy dated 07/01/13 and reviewed 10/10/16 indicated the following: (Name of Corporation) will prohibit abuse, neglect, misappropriation of resident property, and exploitation for all residents. This includes, but is not limited to freedom from corporal punishment, involuntary seclusion, and any physical or chemical restraint not required to treat the resident's medical symptoms. The Center will implement an abuse prohibition program through the folllowing: 1. Screening of potential hires; 2. Training of employees (both new employees and ongoing training for all employees); 3. Prevention of occurrences; 4. Identification of possible incidents and allegations which need investigation; 5. Investigation of incidents and allegations; 6. Protection of patients during investigations; and 7. Reporting of incidents, investigations, and Center response to the results of their investigations.
F 0282 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Provide care by qualified persons according to each resident's written plan of care.** Based on record review and interview, the facility failed to ensure that residents were provided with care and services in accordance with the written plan of care for 1 (R #1) of 3 (R #s 1-3) residents reviewed for falls. This deficient practice placed the resident at risk for injuries resulting from falls such as bruising, skin tears, fractures and pain. The findings are: A. Record review of the Care Plan dated 09/02/16 indicated the following: (Name of R #9) is at risk for further falls due to: impaired mobility, cognitive loss, lack of safety awareness and falls prior to admission. Interventions included: low bed with fall mats to floor bilaterally (both sides), maintain a clutter free environment, scoop mattress to bed and provide resident/caregiver education for safe techniques. B. On 12/29/16 at 11:00 am, during interview with R #1's spouse, she stated that R #1 had a fall on the morning of 12/29/16 and that there were no fall mats at the bed side at this time. C. Record review of photographs date stamped 12/29/16 submitted by R #1's spouse revealed no mats on either side of R #1's bed. D. Record review of the Incident Report dated 12/29/16 indicated the following: Rsd (resident) found on floor per CNA (Certified Nursing Aide), appears to have slid on floor from bed. Assessment done, Rsd alert, responsive, no change in status. V/S (vital signs) stable, neuro (neurological) checks done, no symptoms noted. No s/s (signs/symptoms) of pain r/t (related to) recent fall. E. On 12/30/16 at 11:49 am, during interview with DON (Director of Nursing), she stated that interventions to address R #1's falls included a low bed, fall mats to both sides of the bed and frequent checks by staff. When asked if the fall mats were in place at the time of R #1's fall on 12/29/16, she stated that they were not and that she'd spoken with (Name of CNA #1), who was caring for R #1 that day and counseled her on the importance of appropriately implementing care plan interventions. F. On 12/30/16 at 1:45 pm, during interview with CNA #1, she stated that she was caring for R #1 on 12/29/16 and that, after he had fallen, his spouse notified her that there were no fall mats on either side of the bed. CNA #1 stated that she did not know how long it had been that the mats were not in place but that, as soon as she learned that they were not at the bedside, she retrieved them and put them in place. G. Record review of the facility's Falls Management Policy dated 03/15/16 indicated the following: Patients will be assessed for fall risk as part of the nursing assessment process. Those determined to be at risk will receive appropriate interventions to reduce risk and minimize injury.