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 _____	11/20/2015

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 -** Immediate jeopardy **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** The facility failed to ensure that residents were free from physical and verbal abuse and the resident was not assured of a safe environment free of retaliation by staff. This deficient practice resulted in an Immediate Jeopardy at a scope and severity of J being identified on 11/10/15 at 3:15 pm. The administrator was notified at that time. A Plan of removal was received at 4:15 pm which included the following: 1. Investigations will begin immediately upon Administrator being informed of the event. Administrator/designee will follow the seven steps of incident/accident reporting per policy. 2. If substantiated a plan of correction, that will include re-education, disciplinary action if warranted and evaluation to see if education is effective. This action will be put into place to prevent reoccurrence of stated incident. 3. Social services will meet with the resident alleging abuse to discuss the progress and the outcome of the investigation. 4. Social Services will meet with the resident alleging abuse and ask if the resident feels retaliated against, if so, staff identified will suspended and a new investigation will be started. 5. Resident council will meet on 11/12/2015 and Social Services will educate residents on retaliation and who to report this to. The Nurse Practice Educator (NPE)/designee will educate staff on resident ' s rights to complain/file a grievance without retaliation by 11/15/2015. As a result of the Plan of Removal, the scope and severity was lowered to a level G. Based on record review and interview, the facility failed to ensure that residents were free of verbal abuse, physical abuse, intimidation and restraint for 1 (R #11) of 1 (R #11) residents reviewed for abuse during a complaint investigation. This deficient practice likely resulted in R #11 feeling afraid and uncomfortable in the facility. The findings are: A. On 10/08/15 at 11:58 am, during interview with LPN (Licensed Practical Nurse) #1, she stated that R #11 heard that surveyors were in the building and wanted to speak someone. B. On 10/08/15 at 12:09 pm, during interview, R #11 appeared clean, alert and oriented. R #11 was sitting in her wheelchair, and stated (to the surveyor) that she wanted to know if the State Agency had received her complaint about an incident of alleged abuse. C. On 10/08/15 at 12:09 pm, during interview R #11, stated, I made a report to (Name of Social Services Director) a week ago. I was trying to get some help, for the patient next to me who is comatose because she had sat in her chair with poop for over an hour. They (staff) kept saying 'We'll be right there', but they didn't come. I went to get (Name of Certified Nursing Assistant (CNA) #1). I asked (Name of CNA #1) and she said 'Yeah I'll be right there', she never came. When I went down the hall, she saw me and yelled 'I said I'll be right there!' I went the other way and when I started to come back, she started screaming at me again. She grabbed my wheelchair and then she grabbed my arm. I reported it and I was told that because I screamed back that it didn't warrant any punishment. (Name of Administrator) told me that she talked to the State (State Agency) and that it didn't warrant punishment. (Name of Administrator) said 'Witnesses said it was the two of you (R #11 and CNA #1). 'I (Administrator) want to put you two in a room to apologize to each other.' (Name of Administrator) turned right around and put her (CNA #1) to work in my station and (Name of CNA #1) brings my food tray, and says 'Here' and throws it down. I have a history of abuse and I have always tried to run away and now if I have to deal with this. I feel it (abuse allegation) should've been addressed, and (Name of Administrator) said it had. (Name of CNA #1) still works on the South Unit (where Resident resides). She (CNA #1) came in my room on Tuesday and asked if I wanted a shower and I said I didn't feel good because I don't want to be showered by her. R #11 was asked if she felt afraid, she stated Yes I am. I'm afraid she'll yell at me again. I shouldn't have to be uncomfortable here for a reason like that. R #11 stated (of the alleged incident) It happened Sunday the 27th of September in the evening right around 6 or 7. When she (CNA #1) yelled at me, I went the other way. She (CNA #1) was in room [ROOM NUMBER]. She was in the doorway, I was sitting outside the doorway. I was trying to get away from her and she grabbed the wheelchair. She was holding me from getting away. Then she grabbed my left arm and I pulled away. I just had to get away. During the interview, R #11 started to cry when talking about CNA #1 yelling at her and grabbing her wrist. D. On 10/08/15 at 1:14 pm, during interview with LPN #1 regarding R #11's allegation of abuse, she stated I was doing her dressing, (on 09/28/15), she just was kind of different that day, I asked what was wrong. She started crying a little bit and she said 'I had a rough weekend. On Saturday (Name of CNA #1) was my aide and she raised her voice.' (R #11) said when she was backing up (Name of CNA #1) grabbed her wheelchair and jerked her. (Name of R #11) said 'Let go' and (Name of CNA #1) grabbed her arm. After she told me that, I felt like I had to tell somebody, I talked to (Name of Administrator) and (Name of Director of Nursing (DON)) and they said they would take care of it. (Name of DON) said 'We will talk to her.' She (CNA #1) came back the next day and she was on (Name of R #11's) floor. She (R #11) was scared, she said 'I'm afraid, what if she retaliates?' I told her to tell somebody, to tell me, if that happens. (Name of R #11) talked to (Name of Social Service Director) and (Name of Social Service Director) moved her to the other side (of the facility). I thought that was weird, to move the resident and not the aide. She (R #11) was really uncomfortable. They (Administration staff) continued to put (Name of CNA #1) on her (R #11's) side and do her showers. Now she is very different. She (R #11) told me (Name of Administrator) talked to her and talked to the State (State Agency) and it (the alleged incident) didn't warrant discipline. From my side, I think it should've been reported. She (R #11) is a very social person, she gets along with everybody. I don't want (Name of R #11) to be afraid. She always asks who's working or who's doing showers. (Name of CNA #1) did showers last night, and (Name of R #11) didn't take a shower. If (Name of CNA #1) is doing showers, she is not going to take showers, she is not going to be alone in the shower room with her. (Name of Administrator) told her (R #11) she wanted them to be in the same room to reconcile. I don't think she should be pressured to be in the same room with someone who terrifies her. On the other side (of the facility), all the aides were saying, 'That's the lady you can't touch because she'll tell on you.' The smoke group residents are not talking to (Name of R #11) because of (Name of CNA #1). That's why she isolates. They (Administrative Staff) still are putting her (CNA #1) on showers and putting her on R #11's hall. E. On 10/08/15 at 2:53 pm, during interview regarding the allegation of abuse, the Administrator stated that she was aware of the incident and that When I talked to (Name of R #11), she said I didn't want anything done with this. The Administrator was unable to provide any documentation to indicate that the allegation of abuse had been addressed and/or resolved. F. On 10/08/15 at 3:43 pm, during interview with the Social Services Director (SSD) she stated, I interviewed (Name of R

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 0223 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 1) #11), she had told me that she had asked for help for her roommate. She said a little time had gone by and she went and found (Name of CNA #1). (Name of CNA #1) was coming out of another patient's room. (Name of CNA #1) said 'I know you need help, I just got on the floor.' (Name of R #11) said she went away and when she was coming back down the hall, (Name of CNA #1) yelled at her. (Name of R #11) said she started rolling away and (Name of CNA #1) grabbed the handle (of her wheelchair) and said 'I want to talk to you' and (Name of R #11) said she didn't want to talk to her and she rolled away from the situation. I moved (Name of R #11) to (another unit) for the night. She (R #11) said she was afraid of (Name of CNA #1). (Name of R #11) has a history of abuse by her mother and siblings. (Name of R #11) stated that when (Name of CNA #1) put her hand on her arm it brought up bad memories. I thought it (the move) was best for her mentality. G. On 10/08/15 at 4:46 pm, during interview with R #12 regarding the incident involving R #11, she stated I do remember the one employee (CNA #1) saying 'I know. I will get to it.' She (CNA #1) was harsh about it. She said it loudly. I just saw her harshly tell her. I. Record review of facility's Alleged Perpetrator/Victim Interview Record dated 09/28/15, revealed that (Name of R #11) states (Name of CNA #1) told her she was not yelling at (Name of R #11) and (Name of R #11) tried to move her wheelchair when (Name of CNA #1) grabbed the back of the wheelchair. (Name of R #11) stated 'Let go' and (Name of CNA #1) grabbed (Name of R #11's) arm and stated she wanted to talk to (Name of R #11) and (Name of R #11) said 'No.'
F 0225 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	**1) Hire only people with no legal history of abusing, neglecting or mistreating residents; or 2) report and investigate any acts or reports of abuse, neglect or mistreatment of residents.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility failed to ensure that resident allegations of physical and verbal abuse were investigated and acted upon. Without follow-up, the facility could not ensure that residents remained free of retaliation or harm. This deficient practice resulted in an Immediate Jeopardy at a scope and severity of J being identified on 11/10/15 at 3:15 pm. The administrator was notified at that time. A Plan of removal was received at 4:15 pm which included the following: 1. Investigations will begin immediately upon Administrator being informed of the event. Administrator/designee will follow the seven steps of incident/accident reporting per policy. 2. 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Based on record review and interview, the facility failed to report an allegation of abuse for one (R #11) of one (R #1) residents reviewed for abuse during a complaint investigation. The facilities failure to report an allegation of abuse to the State Agency, likely resulted in R #11 feeling afraid and uncomfortable in the facility. The findings are: A. On 10/08/15 at 11:58 am, during interview with LPN #1, she stated that R #11 heard that surveyors were in the building and wanted to speak someone. B. On 10/08/15 at 12:09 pm, during interview, R #11 appeared clean, alert and oriented. R #11 was sitting in her wheelchair, and stated (to the surveyor) that she wanted to know if the State Agency had received her complaint about an incident of alleged abuse. C. On 10/08/15 at 12:09 pm, during interview R #11, stated, I made a report to (Name of Social Services Director) a week ago. I was trying to get some help, for the patient next to me who is comatose because she had sat in her chair with poop for over an hour. They (staff) kept saying 'We'll be right there', but they didn't come. I went to get (Name of Certified Nursing Assistant (CNA) #1). I asked (Name of CNA #1) and she said 'Yeah I'll be right there', she never came. When I went down the hall, she saw me and yelled I said I'll be right there!' I went the other way and when I started to come back, she started screaming at me again. I'm trying to back up from her because she was screaming at me. She grabbed my wheelchair (indicating the handles of her wheelchair) and then she grabbed my arm. I reported it and I was told that because I screamed back that, that didn't warrant any punishment. (Name of Administrator) told me that she talked to the State (State Agency) and that it didn't warrant punishment. (Name of Administrator) said 'Witnesses said it was the two of you (R #11 and CNA #1). I (Administrator) want to put you two in a room to apologize to each other.' (Name of Administrator) turned right around and put her (CNA #1) to work in my station and (Name of CNA #1) brings my food tray, and says 'Here' and throws it down. I have a history of abuse and I have always tried to run away and now if have to deal with this. I feel it (abuse allegation) should've been addressed, and (Name of Administrator) said it had. (Name of CNA #1) still works on the South Unit (where Resident resides). She (CNA #1) came in my room on Tuesday and asked if I wanted a shower and I said I didn't feel good because I don't want to be showered by her. R #11 was asked if she felt afraid, she stated Yes I am. I'm afraid she'll yell at me again. She (CNA #1) knows I reported her. I spent the night on the other side (referring to another unit) and they (staff) were saying things like 'That's the one you can't touch. And I did tell (Name of Administrator) about that, and she said she would take care of it. Now if feel like I can't talk to anybody. I shouldn't have to be uncomfortable here for a reason like that. R #11 stated (of the alleged incident) It happened Sunday the 27th of September in the evening right around 6 or 7. When she (CNA #1) yelled at me, I went the other way. She (CNA #1) was in room [ROOM NUMBER]. She was in the doorway, I was sitting outside the doorway. I was trying to get away from her and she grabbed the wheelchair. She was holding me from getting away. Then she grabbed my left arm and I pulled away. I just had to get away. During the interview, R #11 started to cry when talking about CNA #1 yelling at her and grabbing her wrist. D. On 10/08/15 at 1:14 pm, during interview with Licensed Practical Nurse (LPN) #1 regarding R #11's allegation of abuse, she stated I was doing her dressing, (on 09/28/15), she just was kind of different that day, I asked what was wrong. She started crying a little bit and she said 'I had a rough weekend. On Saturday (Name of CNA #1) was my aide and she raised her voice.' (R #11) said when she was backing up (Name of CNA #1) grabbed her wheelchair and jerked her. (Name of R #11) said 'Let go' and (Name of CNA #1) grabbed her arm. After she told me that, I felt like I had to tell somebody, I talked to (Name of Administrator) and (Name of Director of Nursing (DON)) and they said they would take care of it. (Name of DON) said 'We will talk to her.' She (CNA #1) came back the next day and she was on (Name of R #11's) floor. She (R #11) was scared, she said 'I'm afraid, what if she retaliates?' I told her to tell somebody, to tell me, if that happens. (Name of R #11) talked to (Name of Social Service Director) and (Name of Social Service Director) moved her to the other side (of the facility). I thought that was weird, to move the resident and not the aide. She (R #11) was really uncomfortable. They (Administration staff) continued to put (Name of CNA #1) on her (R #11's) side and do her showers. Now she is very different. She (R #11) told me (Name of Administrator) talked to her and talked to the State (State Agency) and it (the alleged incident) didn't warrant discipline. From my side, I think it should've been reported. She (R #11) is a very social person, she gets along with everybody. I don't want (Name of R #11) to be afraid. She always asks who's working or who's doing showers. (Name of CNA #1) did showers last night, and (Name of R #11) didn't take a shower. If (Name of CNA #1) is doing showers, she is not going to take showers, she is not going to be alone in the shower room with her. (Name of Administrator) told her (R #11) she wanted them to be in the same room to reconcile. I don't think she should be pressured to be in the same room with someone who terrifies her. On the other side (of the facility), all the aides were saying, 'That's the lady you can't touch because she'll tell on you.' The smoke group residents are not talking to (Name of R #11) because of (Name of CNA #1). That's why she isolates. They (Administrative Staff) still are putting her (CNA #1) on showers and putting her on R #11's hall. E. On 10/08/15 at 2:53 pm, during interview regarding the allegation of abuse, the Administrator stated that she was aware

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F 0225 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 2) of the incident and that When I talked to (Name of R #11), she said I didn't want anything done with this. The Administrator was asked if she reported the allegation of abuse to the State Agency and she stated I didn't. The Administrator confirmed she was made aware of the allegation of abuse from LPN #1. F. On 10/08/15 at 3:43 pm, during interview with the Social Services Director (SSD) she stated, I interviewed (Name of R #11), she had told me that she had asked for help for her roommate. She said a little time had gone by and she went and found (Name of CNA #1). (Name of CNA #1) was coming out of another patient's room. (Name of CNA #1) said 'I know you need help, I just got on the floor.' (Name of R #11) said she went away and when she was coming back down the hall, (Name of CNA #1) yelled at her. (Name of R #11) said she started rolling away and (Name of CNA #1) grabbed the handle (of her wheelchair) and said 'I want to talk to you' and (Name of R #11) said she didn't want to talk to her and she rolled away from the situation. I moved (Name of R #11) to (other unit) for the night. She (R #11) said she was afraid of (Name of CNA #1). (Name of R #11) has a history of abuse by her mother and siblings. (Name of R #11) stated that when (Name of CNA #1) put her hand on her arm it brought up bad memories. I thought it was best for her mentality. G. On 10/08/15 at 4:46 pm, during interview with R #12 regarding the incident involving R #11, she stated I do remember the one employee (CNA #1) saying 'I know. I will get to it.' She (CNA #1) was harsh about it. She said it loudly. I just saw her harshly tell her. H. Record review of the Incident Reports to the State Agency from 07/01/15 to 10/08/15, did not reveal any reports related to R #11. I. Record review of facilities Alleged Perpetrator/Victim Interview Record dated 09/28/15, revealed that (Name of R #11) states (Name of CNA #1) told her she was not yelling at (Name of R #11) and (Name of R #11) tried to move her wheelchair when (Name of CNA #1) grabbed the back of the wheelchair. (Name of R #11) stated 'Let go' and (Name of CNA #1) grabbed (Name of R #11's) arm and stated she wanted to talk to (Name of R #11) and (Name of R #11) said 'No.' J. Record review of facility Abuse Prohibition Policy dated 07/01/13, revealed the following: 1. Upon receiving information concerning a report of suspected or alleged abuse, the Administrator or designee will perform the following: Confirm that the allegation has been reported according to State and federal requirements. 2. The Administrator or designee will report findings of all completed investigations to officials (including the state survey and certification agency) within five working days of the incident or in accordance with state law, and take all necessary, corrective actions depending on the results of the investigation.
F 0226 **Level of harm -** Immediate jeopardy **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** The facility failed to implement its policies and procedures that prohibit mistreatment and neglect of residents, through failing to act on grievances. Without follow-up, the facility was unable to ensure that residents remained free of retaliation or harm. This deficient practice resulted in an Immediate Jeopardy at a scope and severity of J being identified on 11/10/15 at 3:15 pm. The administrator was notified at that time. A Plan of removal was received at 4:15 pm which included the following: 1. Investigations will begin immediately upon Administrator being informed of the event. Administrator/designee will follow the seven steps of incident/accident reporting per policy. 2. If substantiated a plan of correction, that will include re-education, disciplinary action if warranted and evaluation to see if education is effective. This action will be put into place to prevent reoccurrence of stated incident. 3. Social services will meet with the resident alleging abuse to discuss the progress and the outcome of the investigation. 4. Social Services will meet with the resident alleging abuse and ask if the resident feels retaliated against, if so, staff identified will suspended and a new investigation will be started. 5. Resident council will meet on 11/12/2015 and Social Services will educate residents on retaliation and who to report this to. The Nurse Practice Educator (NPE)/designee will educate staff on resident ' s rights to complain/file a grievance without retaliation by 11/15/2015. As a result of the Plan of Removal, the scope and severity was lowered to a level G. Based on record review and interview, the facility failed to implement a policy and procedure for investigating and reporting the results of an investigation for an allegation of abuse or mistreatment to the State Agency (SA) for 1 (R #11) of 1 (R #11) residents reviewed for allegations of abuse/mistreatment. This has the potential to affect the residents in the facility by the facility not being able to determine the cause of the incident, the need for education of staff, and implement needed changes. The findings are: A. On 10/08/15 at 11:58, during interview with LPN #1, she stated that R #11 heard that surveyors were in the building and wanted to speak someone. B. On 10/08/15 at 12:09 pm, during observation, R #11, she appeared clean, alert and oriented. R #11 was sitting in her wheelchair, and stated that she wanted to know if the State Agency had received her complaint about an incident of alleged abuse. C. On 10/08/15 at 12:09 pm, during interview R #11, she stated, I made a report to (Name of Social Services Director) a week ago. I was trying to get some help, for the patient next to me who is comatose because she had sat in her chair with poop for over an hour. They (staff) kept saying 'We'll be right there', but they didn't come. I went to get (Name of Certified Nursing Assistant (CNA) #1). I asked (Name of CNA #1) and she said 'Yeah I'll be right there', she never came. When I went down the hall, she saw me and yelled I said I'll be right there!' I went the other way and when I started to come back, she started screaming at me again. I'm trying to back up from her because she was screaming at me. She grabbed my wheelchair (indicating the handles of her wheelchair) and then she grabbed my arm. I reported it and I was told that because I screamed back, that that didn't warrant any punishment. 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F 0226 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 3) (Administration staff) continued to put (Name of CNA #1) on her (R #11's) side and do her showers. Now she is very different. She (R #11) told me (Name of Administrator) talked to her and talked to the State (State Agency) and it (the alleged incident) that didn't warrant discipline. From my side, I think it should've been reported. She (R #11) is a very social person, she gets along with everybody. I don't want (Name of R #11) to be afraid. She always asks who's working or who's doing showers. (Name of CNA #1) did showers last night, and (Name of R #11) didn't take a shower. If (Name of CNA #1) is doing showers, she is not going to take showers, she is not going to be alone in the shower room with her. (Name of Administrator) told her (R #11) she wanted them to be in the same room to reconcile. I don't think she should be pressured to be in the same room with someone who terrifies her. On the other side (of the facility), all the aides were saying, 'That's the lady you can't touch because she'll tell on you.' The smoke group residents are not talking to (Name of R #11) because of (Name of CNA #1). That's why she isolates. They (Administrative Staff) still are putting her (CNA #1) on showers and putting her on R #11's hall. E. On 10/08/15 at 2:53 pm, during interview regarding the allegation of abuse, the Administrator stated that she was aware of the incident and that When I talked to (Name of R #11), she said I didn't want anything done with this. The Administrator was asked if she reported the allegation of abuse to the State Agency and she stated I didn't. The Administrator confirmed she was made aware of the allegation of abuse from LPN #1. F. On 10/08/15 at 3:43 pm, during interview with the Social Services Director (SSD) she stated, I interviewed (Name of R #11), she had told me that she had asked for help for her roommate. She said a little time had gone by and she went and found (Name of CNA #1). (Name of CNA #1) was coming out of another patient's room. (Name of CNA #1) said 'I know you need help, I just got on the floor.' (Name of R #11) said she went away and when she was coming back down the hall, (Name of CNA #1) yelled at her. (Name of R #11) said she started rolling away and (Name of CNA #1) grabbed the handle (of her wheelchair) and said 'I want to talk to you' and (Name of R #11) said she didn't want to talk to her and she rolled away from the situation. I moved (Name of R #11) to (other unit) for the night. She (R #11) said she was afraid of (Name of CNA #1). (Name of R #11) has a history of abuse by her mother and siblings. (Name of R #11) stated that when (Name of CNA #1) put her hand on her arm it brought up bad memories. I thought it was best for her mentality. G. On 10/08/15 at 4:46 pm, during interview with R #12 regarding the incident involving R #11, she stated I do remember the one employee (CNA #1) saying 'I know. I will get to it.' She (CNA #1) was harsh about it. She said it loudly. I just saw her harshly tell her. H. Record review of the Incident Reports to the State Agency from 07/01/15 through 10/08/15, did not reveal any reports related R #11. I. Record review of facilities Alleged Perpetrator/Victim Interview Record dated 09/28/15, revealed the following: (Name of R #11) states (Name of CNA #1) told her she was not yelling at (Name of R #11) and (Name of R #11) tried to move her wheelchair when (Name of CNA #1) grabbed the back of the wheelchair. (Name of R #11) stated 'Let go' and (Name of CNA #1) grabbed (Name of R #11's) arm and stated she wanted to talk to (Name of R #11) and (Name of R #11) said 'No.' J. Record review of facility Abuse Prohibition Policy dated 07/01/13, revealed the following: 1. Upon receiving information concerning a report of suspected or alleged abuse, the Administrator or designee will perform the following: Confirm that the allegation has been reported according to State and federal requirements. 2. The Administrator or designee will report findings of all completed investigations to officials (including the state survey and certification agency) within five working days of the incident or in accordance with state law, and take all necessary, corrective actions depending on the results of the investigation.
F 0244 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Listen to the resident or family groups or act on their complaints or suggestions.** Based on record review and interview, the facility failed to act upon the grievances and recommendations of the Resident Council regarding activities and smoking times for 1 (R #6) of 1 (R#6) residents reviewed for grievances. This deficient practice has the potential to reduce residents' quality of life through boredom, decreased social interaction and failure to have preferences honored. The findings are: A. Record review of Resident Council Minutes indicated the following: 1. 02/12/14: 6:30 pm smoke break is not being attended by an employee leading to no smoke happening. No documentation was found to indicate that this issue was followed up on and resolved. 2. 03/18/15: 7 pm smoke breaks are still not being done. No documentation was found to indicate that this issue was followed up on and resolved. 3. 06/24/15: 7 pm smoke break not getting done, no staff to do smoke break. No documentation was found to indicate that this issue was followed up on and resolved. 4. 07/15/15: 7 pm smoke break still not being done. No documentation was found to indicate that this issue was followed up on. 5. 08/12/15: 7 pm smoke break still not being done. No documentation was found to indicate that this issue was followed up on and resolved. 6. 06/24/15: Activities are not being done. No documentation of follow up was found. B. On 10/08/15 at 1:30 pm, during interview with R #6, she stated that, activities are a big problem and we brought it up in Resident Council but nothing got done. R #6 stated that several residents have come to her personally and complained about the lack of activities. R #6 stated that there is often a problem getting the evening smoke break done and that this sometimes doesn't occur because there is not a staff member available to accompany the residents outside. C. On 10/09/15 at 10:16 am, during interview with the Administrator, she stated that she'd had complaints about activities running a little late so we've been monitoring it closer. The Administrator did not provide specific information on how the facility was addressing the issue of activities starting late. Regarding smoke breaks not being done, the Administrator stated that she met with the resident council and told the residents the exact times for smoke breaks (7:00 pm), and assigned a Certified Nurse Assistant (CNA) to accompany residents on the evening smoke break. The Administrator was unable to provide documentation of the resident council minutes that indicated that this discussion occurred but acknowledged that the complaint about smoke breaks continued to be an issue.
F 0248 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Provide activities to meet the interests and needs of each resident.** Based on observation, interview and record review, the facility failed to ensure that an ongoing program of activities was provided that was designed to meet residents' interests for 2 (R #s 6 and 10) of 4 (R #s 6, 8, 9 and 10) residents reviewed for activities. This deficient practice is likely to reduce residents' quality of life through boredom, decreased social interaction, and isolation. The findings are: A. On 10/08/15 at 11:10 am, during interview with LPN #1, she stated that she was concerned with the lack of activities at the facility and that there were never any activities going on unless the state is here. LPN #1 stated that she was very concerned that the residents were being short changed due to the lack of activities. B. On 10/08/15 at 11:20 am during interview with the Activities Director (AD), she stated that she does not document when residents attend activities. The AD provided a notebook with August 2015 activity logs for each resident but these were all blank and she stated that, I didn't know I was supposed to be documenting activities until we had our survey a couple of months ago, so I haven't been in the habit of documenting them and honestly haven't been doing it. The AD was unable to answer how she tracks and trends whether residents are engaged in activities or if there are patterns of residents isolating themselves. When asked how she ensured that residents are being engaged in activities that meet their interests, the AD stated, I don't know. C. Record review of Resident Council Minutes dated indicated that Activities are not being done. No documentation of follow up was found. D. Record review of the October 2015 Activities Calendar indicated the activity Coffee Talk scheduled for 11:30 am. E. On 10/08/15 at 11:45 am, during observation, it was determined that the scheduled Coffee Talk activity was not occurring. F. On 10/08/15 at 1:30 pm, during interview with R #6, she stated that activities are a big problem here and we've brought it up in the Resident Council Meetings. R #6 stated that the lack of activities was brought up in the Resident Council Meeting back in June and again in August 2015 but that, for the August meeting, It (the activities complaint) wasn't on the

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	325036	A. BUILDING _____ B. WING _____	11/20/2015

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

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F 0248 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 4) minutes that went to the administrator so nothing was done about it. R #6 stated that several other residents have come to her personally and complained about the lack of activities. R #6 stated that the residents really enjoy the Jeopardy activity but that this often didn't occur even when it was on the activities schedule. R #6 stated that the Activities Assistant does all of the paperwork and that the AD is supposed to do the activities but that the activities don't get done and that instead of conducting activities, the AD sits in her office on her phone. R #6 stated that there are never any evening activities so we (the residents) got together on our own and set up a movie night twice a week. R #6 stated that the AD does not go around to invite residents nor does she announce that activities are going to occur. R #6 also stated that there is supposed to be an outing a month but stated that there had only been 2 outings in a year. R #6 stated that there was often a problem getting the evening smoke break done because there was not a staff member available to accompany residents outside to the smoking area. G. On 10/08/15 at 2:36 pm, observation of the Bingo activity revealed that 5 residents were participating and that a volunteer was calling out the Bingo numbers. R # 6 and R #10 were not in attendance. H. Record review of the October 2015 Activities Calendar indicated a Bible Study activity scheduled for 3:30 pm. I. On 10/08/15 at 3:46 pm, during observation, Bible Study activity scheduled for 3:30 pm was not occurring. J. On 10/08/15 at 3:55 pm, during interview with R #10, he that he was doing physical therapy but other than that, he had not participated in any organized activities and that nobody came by to invite him to activities or encourage him to attend. K. On 10/09/15 at 10:16 am, during interview with the Administrator, she stated that she'd had complaints about activities running a little late so we've been monitoring it closer. The Administrator did not provide specific information on how the facility was addressing the issue of activities starting late. Regarding smoke breaks not being done, the Administrator stated that she met with the resident council and told the residents the exact times for smoke breaks (7:00 pm), and assigned a Certified Nurse Assistant (CNA) to accompany residents on the evening smoke break. The Administrator was unable to provide documentation that this discussion occurred but acknowledged that the complaint about smoke breaks continued to be an issue. L. On 10/09/15 at 10:20 am, during interview with the Activities Director, she stated that regarding bingo, she would like to see more than 5 residents participating but that on 10/08/15, she did not go around to invite people to attend nor did she announce that the activity was occurring. The AD stated that the coffee talk coffee talk activity is usually done right before lunch and that this is handled by the CNAs who will bring coffee out to the residents and the residents will socialize. The AD stated that she was unsure of why this activity did not occur. The AD stated that Bible Study is done by a volunteer and that this was scheduled for 3:30 pm but that the activity did not occur until 3:50 pm because the staff were gathering up the residents and getting them to the dining room.
F 0282 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide care by qualified persons according to each resident's written plan of care.** Based on observation and interview, the facility failed to implement the care plan by not ensuring that residents were engaged in meaningful activities for 1 (R #6) of 4 (R #s 6, 8, 9 and 10) residents reviewed for activities. This deficient practice has the potential to reduce residents' quality of life through boredom and decreased social interaction. The findings are: A. Record review of R #6's Care Plan dated 08/15/15 indicated the following: Focus: (R #6) would benefit from opportunities to make decisions/choices related to self-directed involvement in meaningful activities .She enjoys being resident council president, bingo, jeopardy, socializing with peers during smoke breaks, staying up late at night and watching TV. Goals: (R #6) will indicate satisfaction in daily/routine activities as evidenced by verbalizing satisfaction, increase in affect during participation, increased focus and attention to activities of choice through next review. Interventions: Inform resident of facility happenings, invite and assist resident, as needed, to activities of interest (bingo, jeopardy, smoke breaks, resident council), provide materials of interest. B. On 10/08/15 at 11:10 am, during interview with Licensed Practical Nurse (LPN) #1, she stated that she was concerned with the lack of activities at the facility and that there are never any activities going on unless the state is here. LPN #1 stated that she was very concerned that the residents were being short changed due to the lack of activities. C. On 10/08/15 at 11:38 am, during observation of the activity room, the Coffee Talk activity that was scheduled for 11:30 am was not occurring. D. On 10/08/15 at 1:30 pm, during interview with R #6, she stated that activities are a big problem here and we brought it up in Resident Council. R #6 stated that several other residents have come to her personally and complained about the lack of activities. R #6 stated that the residents really like the Jeopardy activity but that this doesn't occur even though it is often on the activities schedule. R #6 stated that the Activities Assistant does all of the paperwork and that the Activities Director (AD) is supposed to do the activities but that the activities don't get done. R #6 stated that instead of conducting activities, the AD sits in her office on her phone. and that there are never any evening activities so we (the residents) got together on our own and set up a movie night twice a week. R #6 stated that the AD does not go around to invite residents nor does she announce that activities are going to occur. R #6 stated that the lack of activities was brought up in the Resident Council Meeting back in June and again in August 2015 but that, for the August meeting, It (the activities complaint) wasn't on the minutes that went to the administrator so nothing was done about it. R #6 also stated that there is supposed to be one outing a month but stated that there has only been 2 outings in a year. E. On 10/08/15 at 2:40 pm, observation revealed 5 residents participating in the Bingo activity scheduled for 2:30 pm. R #6 was not in attendance. F. Record review of Activities Participation Log for 2015 revealed the following: 1. August 2015 Log was blank 2. No other Activities Participation Logs were found G. On 10/08/15 at 11:20 am, during interview with the AD, she stated that the facility does activities such as Bingo, cooking and card games. The AD stated that for residents who are not as mobile, we do one to one activities with them. The AD stated that she did not document when residents attend activities and provided a notebook with August 2015 activity logs for each resident but these were all blank. The AD stated, I didn't know I was supposed to be documenting activities until we had our survey and that I have not been in the habit of documenting (activities on the log) so I honestly haven't been doing it. When asked how she tracks and trends whether residents are being engaged in activities or whether there are patterns of isolation, the AD stated, I don't know. When asked for documentation to indicate that R #6 was participating in activities per her care plan, the AD stated, I don't have anything and was unable to say whether R #6 had been participating in activities. H. On 10/08/15 at 3:46 pm, during observation, Bible Study activity scheduled for 3:30 pm was not occurring. I. On 10/09/15 at 10:20 am, during interview with the Activities Director, she stated that regarding bingo, she would like to see more than 5 residents participating but that on 10/08/15, she did not go around to invite people to attend nor did she announce that the activity was occurring. The AD stated that the Coffee Talk activity was usually done right before lunch and that this was handled by the CNAs who will bring coffee out to the residents and the residents will socialize. The AD stated that she was unsure of why this activity did not occur. The AD stated that Bible Study is done by a volunteer and that this was scheduled for 3:30 pm but that the activity did not occur until 3:50 pm because the staff were gathering up the residents and getting them to the dining room. The AD stated that outings are scheduled for once a month but that the facility had not been able to do outings for about 7 months since the facility's van was broken. The AD stated that no activity replaced the outings other than whatever else was scheduled.
F 0514 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	**Keep accurate, complete and organized clinical records on each resident that meet professional standards** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This is a repeat deficiency from a recertification survey conducted on 07/24/15. Based on record review and interview, the facility failed to maintain accurate and complete records for 4 (R #s 2, 6, 10 and

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F 0514 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	(continued... from page 5) 13) of 13 (R #s 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 13, 14 and 15) residents reviewed for activities, Activities of Daily Living (ADLs), and diagnostic services. This deficient practice has the potential to prevent identification of patterns of isolation due to residents not being engaged in meaningful activities, prevent identification of problems related to bowel elimination patterns and prevent residents from experiencing anxiety due to unnecessary diagnostic tests. The findings are: Findings Related to Activities Documentation A. Record review of the Activities Participation Log dated 08/01/15 to 08/31/15 for R # 6 indicated that the log was blank. B. No Activities Participation Logs were found for September 2015 and October 2015 for R #s 6 and 10. C. On 10/08/15 at 11:20 am, during interview with the Activities Director (AD), she stated that she does not document when residents attend activities. The AD provided a notebook with August 2015 activity logs for each resident but these were all blank and she stated that, I didn't know I was supposed to be documenting activities until we had our survey a couple of months ago, so I haven't been in the habit of documenting them and honestly haven't been doing it. The AD was unable to answer how she tracks and trends whether residents are engaged in activities or if there are patterns of residents isolating themselves. When asked how she ensured that residents are being engaged in activities that meet their interests, the AD stated, I don't know. Findings related to Bowel Elimination for R #2 D. Record review of the Activities of Daily Living (ADLs) Record dated 09/28/15 to 09/30/15, revealed incomplete documentation for the bowel section. For day shift, status, consistency, size, and number are left blank. There is no documentation showing if R #2 had a bowel movement during the day. In addition, on 09/29/15 and 09/30/15, for evening shift there are X's in the status box and a line through consistency, size, and number. E. Record review of the Activities of Daily Living (ADLs) Record dated 10/01/15 to 10/31/15, revealed incomplete documentation for the bowel section. For night shift on 10/01/15 to 10/07/15, the documentation in the status box, is illegible. Staff were unable to determine for sure if the documentation are CNA initials or 'NA (non applicable).' For day shift on 10/01/15 to 10/08/15 is blank. For evening shift on 10/02/15, 10/03/15, and 10/07/15 entries are left blank. For the days that are blank, staff are unable to determine if R #2 had a bowel movement during that time. F. On 10/09/15 at 8:45 am, during interview with Licensed Practical Nurse (LPN) #1, she was asked if the bowel section on the ADL Record was complete, she stated Nobody is putting their initials for days (day shift). There is a lot of holes in the book. LPN #1 confirmed that the CNAs are supposed to document in the ADL Record everyday and that it's not being done. G. On 10/09/15 at 9:41 am, during interview with the Registered Nurse (RN) she stated So he (R #2) was constipated when he first got here and we gave him a suppository, and he was able to have a BM (bowel movement). The RN was asked if she documented when the suppository was administered? The RN stated It should be on the MAR (Medication Administration Record) and if it's not then I passed it on in report. We would document. She confirmed there is no documentation for the suppository stating Nope, I guess not, that's not good. H. On 10/09/15 at 10:06 am, during interview the Director of Nursing (DON) was asked about the documentation of the September 2015 and October 2015 ADL Records, the DON stated I know there is an 'I' for incontinent, on the 8th. These other ones are signatures, it doesn't say the size, but it does show he had a BM on the 4th on evening shift. They look like signatures only because I don't know what they say. The 'I's, I can read. I would need to clarify if he had a BM. Looking on here the documentation that you are supposed to use, shows a BM on the 4th and the day of the 8th and night of the 9th. The other stuff doesn't meet the requirements. The DON was asked if the administration of a suppository should be documented, she stated Yes, in the progress notes. The DON confirmed there is no documentation in the progress notes. The DON also stated There is not supposed to be holes in the charting. Holes are unacceptable. I. Record review of the Nursing Progress notes dated 09/26/15 to 10/06/15, did not reveal any notes stating the R #2 was administered a suppository and whether it was effective or not. Findings related to diagnostic services for R #13: J. Record review of R #13's medical chart revealed a Radiology Report dated 09/05/15 which indicated R #13 received an x-ray of his right knee on 09/05/15. K. Record review of R #13's Physician order [REDACTED]. L. On 11/20/15 at 1:09 pm, during an interview with the DON (Director of Nursing), she stated she was unable to locate R #13's physician's orders [REDACTED]. The DON stated she checked with medical records and they could not locate it either. The DON stated the physician orders [REDACTED].
F 0520 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Set up an ongoing quality assessment and assurance group to review quality deficiencies quarterly, and develop corrective plans of action.** Based on record review and interview, the facility failed to ensure that a physician attended Quality Assessment and Assurance (QA&A) meetings quarterly. This deficient practice could result in quality issues not being identified and addressed which presents a risk of potential harm to all 78 residents listed on the Alphabetic List provided by the Administrator on 11/20/15. The findings are: A. Record review of the Monthly QA&A Meeting Sign-In Sheets for the third quarter (July 2015-September 2015) indicated that a physician did not attend the meeting. B. On 11/20/15 at 1:01 pm, during interview with the Administrator, she stated that there was no physician in attendance at the third quarter (July 2015-September 2015) QA&A Meeting because the physician at the time, wasn't doing a good job of attending the meetings.