Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	5805	A. BUILDING: _____ B. WING _____	R-C 07/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARBORS OF DEL REY	3731 DEL REY BLVD LAS CRUCES, NM 88012

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{A 000}	Initial Comments The following deficiencies were cited during an offsite Revisit survey completed on [redacted]23 for the state requirements of 7 NMAC 8.2, Regulations for Assisted Living for Adults. Census (23)	{A 000}	VLC shall insure that all suspected cases or known incidents of resident abuse, neglect or exploitation are reported in accordance with 7.1.13 NMAC. : (A032) Executive Director and or Assistant Executive Director and Facility Nurse will comply with all Incident Reporting, Intake Processing , & Training Requirements . VLC Executive Director and or Assistant Executive Director and Facility Nurse will review regulations tag 7.1.13 NMAC (A032) quarterly to ensure compliance .	7/26/2023 On-going 7/26/2023 On-going
{A 032}	7 NMAC 8.2.32 Reporting of Incidents REPORTING OF INCIDENTS: A. The facility shall insure that all suspected cases or known incidents of resident abuse, neglect or exploitation are reported in accordance with 7.1.13 NMAC. (1) The facility shall also report any incident or unusual occurrence which has or could threaten the health, safety, or welfare of the residents and staff to the licensing authority complaint hotline within twenty-four (24) hours or by the next business day, if it is a weekend or a holiday. (2) The facility shall not delay a report to the complaint hotline while an internal investigation is conducted. B. The facility is responsible for conducting and documenting the investigation of all incidents within five (5) business days and shall submit a copy of the investigation report to the licensing authority. A copy of the report and the documentation, including the date and time that it was submitted to the licensing authority, shall be maintained on file at the facility. The investigation shall include the following: (1) a narrative description of the incident; (2) the result of the facility's investigation shall be recorded on the state approved incident report form for the current year, pursuant to 7.1.13 NMAC; and (3) plans for further actions in response to the incident.	{A 032}		

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{A 032}	Continued From page 1 [7.8.2.32 NMAC - Rp, 7.8.2.32 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: This is a repeated deficiency from survey dated [redacted]/22. 7.8.2.32 A (1) and B 7.1.13 INCIDENT REPORTING, INTAKE, PROCESSING AND TRAINING REQUIREMENTS Refer to 7.1.13.7 W. & 8 B. (2) W. "Reportable incident" means possible abuse, neglect, exploitation, injuries of unknown origin and other events including but not limited to falls which cause injury, unexpected death, elopement, medication error which causes or is likely to cause harm, failure to follow a doctor 's order or an ISP or any other incident which may evidence abuse, neglect, or exploitation. B. (2) Division incident report form and notification by licensed health care facilities: The licensed health care facility shall report incidents utilizing the division's incident report form consistent with the requirements of the division's incident management system guide and CMS regulations as applicable. The licensed health care facility shall ensure that all incident report forms alleging abuse, neglect, exploitation, injuries of unknown origin or other reportable incidents are submitted by a reporter with direct knowledge of an incident, are completed on the bureau's incident report form and received by the	{A 032}		

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{A 032}	Continued From page 2 division within twenty-four (24) hours of an incident or allegation of an incident or the next business day if the incident occurs on a weekend or a holiday. The licensed health care facility shall ensure that the reporter with the most direct knowledge of the incident assists with the preparation of the incident report form. Based on record review and interview, the facility failed to ensure for [redacted] residents whose Internal Incident Reports were reviewed for compliance that: 1. The facility reported incidents of unusual occurrence which has, or could threaten the health, safety, or welfare of the residents and staff to the Licensing Authority within twenty-four (24) hours or by the next business day, if it is a weekend or a holiday. 2. The facility conducted an internal investigation, and submitted an investigation follow-up report to the Licensing Authority within five (5) business days from the date an incident occurred. These deficient practices could likely result in the residents to be at risk of harm, injury, and/or death, if incidents occur and there is no oversight by the Licensing Authority. The findings are: Resident #1: A. Record review of R #1's Internal Incident Report (dated 04/09/23) revealed: 1. Direct Care Staff (DCS) #1 reported the DCS on the night shift said that R #1 wanted to get out of bed in the morning, and when they (day shift DCS) went in to check [redacted] during their morning rounds at 8:24 am, they found R #1 laying on the floor [redacted]	{A 032}		

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{A 032}	Continued From page 3 2. R #1 was transferred back to [redacted] by the day shift DCS, and noted that R #1 was experiencing pain on [redacted] from a previous fall that occurred on [redacted] (reported to the Licensing Authority) and had some slight redness on [redacted] 3. DCS #1 reported that hospice was called to notify them about the fall, and because she was not experiencing pain from the current fall, they did not complete an immediate assessment. B. On 07/24/23 at 2:00 pm, during an interview with the Administrator, she stated: 1. R #1 has a tendency to scoot [redacted] to the edge of the bed and will slide off, and does not believe that [redacted] a the time of the incident. 2. R #1 was found by the DCS beside [redacted] on the floor. 3. Progress notes found in R #1's file reported that [redacted]' and did not verbalize anything else as to how [redacted] fallen. 4. DCS (unknown) from night shift, reported to her that R #1 wanted to get out of bed and the Administrator does not know if [redacted] tried calling for help before getting up, but [redacted] able to bear any weight and would try to get up on [redacted] own. 5. R #1 had a previous fall on [redacted] 23 and [redacted] ight hip. 6. The facility did not report the incident that occurred on [redacted] /23, to the Licensing Authority, did not conduct an internal investigation, or submit a follow-up investigation report within 5 business days from the date of the incident. C. On [redacted] /23 at 2:37 pm, during an interview with the DCS #1, he confirmed: 1. R #1 was trying to get out of bed on [redacted] own, rolled out of it, and R #1 could not recall what had	{A 032}		

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{A 032}	Continued From page 4 happened. 2. After the incident, DCS #1 spoke to R #1's [redacted] POA (Power of Attorney) and [redacted] came out to do an assessment and determined that R #1 was stable. 3. R #1 cannot get out of bed on [redacted]own, but does not like to wait for assistance, and because of [redacted] will forget, think [redacted] walk, and then try to get up on [redacted] own. 4. R #1 usually calls out for assistance but did not call for help on the morning of the incident. 5. He does not remember if R #1 had injuries from that incident but recalls [redacted] on a fall that [redacted] previously. Resident #2: D. Record review of R #2's Internal Incident Report (dated [redacted]/23) revealed that R #4 took R #2's [redacted] then R #2 got up and hit R #4 several times on [redacted] R #4's) hand. R #4 then proceeded to hit R #2 in the face with a closed fist. E. On [redacted]23 at 2:00 pm, during an interview, the Administrator stated/confirmed the following: 1. She (Administrator) was told that R #4 wanted to grab R #2's [redacted] so R #2 pulled the [redacted] back, and then R #4 hit R #2 in the face with a closed fist. 2. R #4 is a wanderer and has a history of grabbing at people and at other residents' belongings. 3. There were not any prior incidents between R #2 and R #4. 4. R #4 does have [redacted] and has become more [redacted] ately, but DCS have been able to redirect [redacted] 5. The facility did not report the incident between	{A 032}		

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{A 032}	Continued From page 5 R #2 and R #4 to the Licensing Authority, did not conduct an internal investigation, or submit a follow-up investigation report within 5 business days from the date of the incident. F. On [redacted]/23 at 2:37 pm, during an interview with the DCS #1, he confirmed: 1. R #4 was trying to take R #2's [redacted], R #2 became [redacted] the two residents started fighting and had to be separated by another DCS (unknown). 2. R#4 gets [redacted] once in a while because [redacted]	{A 032}		

Joy A. Gomez - Executive Director