

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROV DER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>2258</b>	(X2) MULT PLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  C <b>02/22/2019</b>
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NAME OF PROVIDER OR SUPPLIER  <b>WOODMARK AT UPTOWN (THE)</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>7201 PROSPECT PLACE NE ALBUQUERQUE, NM 87110</b>
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A 000	<p>Initial Comments</p> <p>The following deficiencies were cited as a result of a Complaint survey completed on 02/22/19 for the state requirements of 7 NMAC 8.2, Regulations for Assisted Living Facilities.</p> <p>Complaint # 31878 was unsubstantiated with no deficits cited. Complaint # 33882 was unsubstantiated with no deficits cited. Complaint # 30414 was unsubstantiated with deficits cited.</p>	A 000		
A 032	<p>7 NMAC 8.2.32 Reporting of Incidents</p> <p>REPORTING OF INCIDENTS:</p> <p>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.</p> <p>(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.</p> <p>(2) The facility shall not delay a report to the complaint hotline while an internal investigation is conducted.</p> <p>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:</p> <p>(1) a narrative description of the incident; (2) the result of the facility's investigation shall be</p>	A 032		

Division of Health Improvement LABORATORY D RECTOR'S OR PROV DER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE <b>02/22/19</b>
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A 032	<p>Continued From page 1</p> <p>recorded on the state approved incident report form for the current year, pursuant to 7.1.13 NMAC; and</p> <p>(3) plans for further actions in response to the incident.</p> <p>[7.8.2.32 NMAC - Rp, 7.8.2.32 NMAC, 01/15/2010]</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>7.8.2.32 A (1) B</p> <p>7.1.13 INCIDENT REPORTING, INTAKE, PROCESSING AND TRAINING REQUIREMENTS</p> <p>Refer to 7.1.13.7 W. &amp; 8 B. (2)</p> <p>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.</p> <p>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</p>	A 032		

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A 032	<p>Continued From page 2</p> <p>knowledge of an incident, are completed on the bureau's incident report form and received by the 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.</p> <p>Based on record review and interview, the facility failed to ensure that an incidents of suspected abuse, neglect, exploitation:</p> <ol style="list-style-type: none"> <li>1. Were reported to the Licensing Authority within twenty-four (24) hours or the next business day if a holiday or weekend.</li> <li>2. That a follow-up investigation report was submitted to the Licensing Authority within 5 business days from the date the incident occurred.</li> </ol> <p>These deficient practices have the potential for all 84 (R #s 1-84) residents identified on the census provided by Administrator on 02/21/19, to be at risk of harm, injury, and/or death, if there is no oversight by the Licensing Authority because the facility failed to:</p> <ol style="list-style-type: none"> <li>1. Report incidents of suspected abuse, neglect, and exploitation within twenty-four (24) hours or the next business day if a weekend or holiday.</li> <li>2. Submit investigation follow-up reports within five (5) business days days after the incident. The findings are:</li> </ol> <p>A. Record review of R #1's clinical notes dated 05/31/17 revealed [Name of R #1] asked the nurse to come to [redacted] room to check on a tear in [redacted] due to being handled roughly by Direct Care Staff (DCS #1). R #1 complained that DCS</p>	A 032		

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A 032	<p>Continued From page 3</p> <p>#1 shoved a wet wash cloth into [REDACTED] and then pulled it out, causing the tear."</p> <p>B. Record review of the facility's self-report dated 09/08/17 for the incident dated 05/31/17 of suspected abuse revealed that the incident report was not submitted to the Licensing Authority within twenty-four (24) hours or the next business day if a weekend or holiday.</p> <p>C. Record review of the facility's follow-up investigation report for R #1 received by the Licensing Authority on 10/11/17 revealed that the follow-up investigation report was not submitted within 5-business days from the date the incident (05/31/17).</p> <p>D. On 02/22/19 at 2:50 pm, during an interview with the Administrator, she confirmed the:</p> <ol style="list-style-type: none"> <li>1. Facility's self report of suspected suspected abuse of R #1 by DCS #1 was not submitted to the Licensing Authority within within twenty-four (24) hours or the next business day if a holiday or weekend.</li> <li>2. Investigation follow-up report was not submitted to the Licensing Authority within five (5) business days from the date the incident (05/31/17).</li> </ol>	A 032		
A 070	<p>7 NMAC 8.2.70 Incorporated and Related Rules and Codes</p> <p>INCORPORATED AND RELATED RULES AND CODES: The facilities that are subject to this rule are also subject to other rules, codes and standards that may, from time to time, be amended. This includes the following:</p> <p>A. Health Facility Licensure Fees and Procedures, New Mexico Department of Health,</p>	A 070		

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A 070	<p>Continued From page 4</p> <p>7.1.7 NMAC. B. Health Facility Sanctions and Civil Monetary Penalties, New Mexico Department of Health, 7.1.8 NMAC. C. Adjudicatory Hearings for Licensed Facilities, New Mexico Department of Health, 7.1.2 NMAC. D. Caregiver's Criminal History Screening Requirements, 7.1.9 NMAC. E. Employee Abuse Registry 7.1.12 NMAC. F. Incident Reporting, Intake Processing and Training Requirements 7.1.13 NMAC. [7.8.2.70 NMAC - N, 01/15/2010]</p> <p>This REQUIREMENT is not met as evidenced by: 7.8.2.70 F</p> <p>7.1.13 INCIDENT REPORTING, INTAKE, PROCESSING AND TRAINING REQUIREMENTS</p> <p>Refer to 7.1.13.7 W. &amp; 8 B. (2)</p> <p>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.</p> <p>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</p>	A 070		

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A 070	<p>Continued From page 5</p> <p>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 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.</p> <p>Based on record review and interview, the facility failed to ensure that incidents of suspected abuse, neglect, exploitation:</p> <ol style="list-style-type: none"> <li>1. Were reported to the Licensing Authority within twenty-four (24) hours or the next business day if a holiday or weekend.</li> <li>2. That a follow-up investigation report was submitted to the Licensing Authority within five (5) business days from the date the incident occurred</li> </ol> <p>These deficient practices have the potential for all 84 (R #s 1-84) residents identified on the census provided by Administrator on 02/21/19, to be at risk of harm, injury, and/or death, if there is no oversight by the Licensing Authority because the facility failed to:</p> <ol style="list-style-type: none"> <li>1. Report incidents of suspected abuse, neglect, and exploitation twenty-four (24) hours or the next business day if a weekend or holiday.</li> <li>2. Submit investigation follow-up reports within five (5) business days after the incident.</li> </ol> <p>The findings are:</p>	A 070		

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A 070	<p>Continued From page 6</p> <p>A. Record review of R #1's clinical notes (dated 05/31/17) revealed, that "[Name of R #1] asked the nurse to [redacted] room to check on a tear in [redacted] due to being handled roughly by Direct Care Staff (DCS #1). [Name of R #1] complained that DCS #1 shoved a wet wash cloth into [redacted] then pulled it out causing the tear."</p> <p>B. Record review of the facility's self-report (dated 09/08/17) for the 05/31/17 incident of suspected abuse revealed that the incident report was not submitted to the Licensing Authority within twenty-four (24) hours or the next business day if a weekend or holiday.</p> <p>C. Record review of the facility's follow-up investigation report for R #1 received by the Licensing Authority on 10/11/19 revealed, that the follow-up investigation report was not submitted within 5-business days from the date the incident (05/31/17).</p> <p>D. On 02/22/19 at 2:50 pm, during an interview with the Administrator, she confirmed that the:</p> <ol style="list-style-type: none"> <li>1. Facility's self report of suspected suspected abuse of R #1 by DCS #1 was not submitted to the Licensing Authority within 24-hours or the next business day if a holiday or weekend.</li> <li>2. Investigation follow-up report was not submitted to the Licensing Authority within 5-business days from the date the incident (05/31/17).</li> </ol>	A 070		