Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2084	A. BUILDING: ______ B. WING ______	C 02/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WEST RIDGE VILLAGE	**3130 VISTA GRANDE DR NW ALBUQUERQUE, NM 87120**

(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
8 000	Initial Comments The following deficiency was cited during a Complaint survey completed on 02/13/25 for the state requirements of NMAC 8.370.14, Regulations for Assisted Living Facilities for Adults. Resident Census: ██ Complaint Intake NM ██████ was investigated, and deficiencies were not cited. Complaint Intake NM ██████ was investigated, and deficiency was cited.	8 000		
8 032	8 NMAC 370.14.32 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 8.370.9 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 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 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	8 032		

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8 032	Continued From page 1 recorded on the state approved incident report form for the current year, pursuant to 8.370.9 NMAC; and (3) plans for further actions in response to the incident. [8.370.14.32 NMAC - N, 7/1/2024] This REQUIREMENT is not met as evidenced by: 8.370.14.32 A. (2) B 8.370.9 INCIDENT REPORTING, INTAKE, PROCESSING AND TRAINING REQUIREMENTS Refer to 8.370.9.7 V. and 8 B. (2) V. "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	8 032		

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8 032	Continued From page 2 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. Based on record review and interview, the facility failed to ensure for 1 (R #1) of ██ (R #1-██) residents that: 1. All suspected cases of resident exploitation were reported to the Licensing Authority within twenty-four (24) hours or by the next business day if it is a weekend or a holiday. 2. An internal investigation was conducted and a follow-up report was submitted to the Licensing Authority (LA) within five (5) business days from when an incident occurred. These deficient practices could likely result in resident's experiencing financial loss if suspected cases of exploitation are not reported to the Licensing Authority and an internal investigation is not completed. The findings are: A. Record review of complaint intake ██ received on 01/23/24 revealed, on dates 01/05/24 through 01/08/24 R #1 reported to the Owner of the facility that caregiver [name of Direct Care Staff (DCS) #3] had taken money from ██ R #1 checked ██ bank account and determined that DCS #3 had used her Automated Teller Machine (ATM) card at Speedway gas station for $85.01, as well had taken one of ██ checks and cashed for $200.00.	8 032		

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8 032	Continued From page 3 B. On 02/11/25 at 09:26 am, during an interview, Owner/Administrator stated in January 2024, R #1 told [redacted] DCS #3 had taken checks from [redacted] and cashed them. C. On 02/12/25 at 10:49 am, during an interview, the House Manager stated that he was aware of the suspected exploitation and confirmed the Owner did not report the incident to the Licensing Authority or conduct an internal investigation and submit the findings in a follow-up report to the Licensing Authority in a timely manner.	8 032		