STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2043	A. BUILDING: _____ B. WING _____	C 05/03/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALL-CARE ASSISTED LIVING LLC	**1001 YORK DRIVE CLOVIS, NM 88101**

(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 a Complaint survey completed on 05/03/19 for the state requirements of 7 NMAC 8.2, Regulations for Assisted Living. Complaint Intake NM#36353 was substantiated with deficiencies cited.	A 000		
A 025	7 NMAC 8.2.25 Resident Evaluation RESIDENT EVALUATION: A. A resident evaluation shall be completed by an appropriate staff member within fifteen (15) days prior to admission to determine the level of assistance that is needed and if the level of services required by the resident can be met by the facility. B. The initial resident evaluation shall establish a baseline in the resident ' s functional status and thereafter assist with identifying resident changes. The resident evaluation shall be reviewed and updated at a minimum of every six (6) months or when there is a significant change in the resident ' s health status. C. The resident ' s evaluation shall be documented on a resident evaluation form and at a minimum include the following abilities, behaviors or status: (1) activities of daily living; (2) cognitive abilities; reasoning and perception; the ability to articulate thoughts, memory function or impairment, etc; (3) communication and hearing; ability to communicate needs and understand instructions, etc; (4) vision; (5) physical functioning and skeletal problems; (6) incontinence of bowel/bladder;	A 025		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2043	A. BUILDING: _____ B. WING _____	C 05/03/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALL-CARE ASSISTED LIVING LLC	1001 YORK DRIVE CLOVIS, NM 88101

(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 025	Continued From page 1 (7) psychosocial well-being; (8) mood and behavior; (9) activity interests; (10) diagnoses; (11) health conditions; (12) nutritional status; (13) oral or dental status; (14) skin conditions; (15) medication use and level of assistance needed with medications; (16) special treatments and procedures or special medical needs such as hospice; and (17) safety needs/high risk behaviors; history of falls agitation, wandering, fire safety issues, etc. D. The resident evaluation shall include a history and physical examination and an evaluation report by a physician or a physician extender within six (6) months of admission. A resident shall have a medical evaluation by a physician or a physician extender at least annually. E. The resident evaluation shall be reviewed and if needed revised by a licensed practical nurse, registered nurse or physician extender at the time the individual service plan is reviewed, at a minimum of every six (6) months or when a significant change in health status occurs. [7.8.2.25 NMAC - Rp, 7.8.2.25 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.25 A B Based on record review and interview the facility failed to ensure for 3 (R #s 1-2 & 4) of 4 (R #s 1-	A 025		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2043	A. BUILDING: _____ B. WING _____	C 05/03/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALL-CARE ASSISTED LIVING LLC	1001 YORK DRIVE CLOVIS, NM 88101

(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 025	Continued From page 2 4) residents whose Evaluations reviewed for compliance were: 1. Completed within fifteen (15) days prior to admission. 2. Reviewed and updated at a minimum of every six (6) months. 3. Updated when there is a change in condition. This deficient practice has the potential for residents to be at risk of harm or injuries if the they are not receiving the correct care/services needed, because the evaluations had not been completed or updated upon admission or when a change in condition occurs and the Direct Care Staff (DCS) do not know what care/services to provide. The findings are: A. Record review of R #1's resident file revealed that: 1. Evaluations dated [redacted]/18 and [redacted]/18 revealed that they were not updated to reflect R #1's frequent [redacted] from [redacted]/18 thru [redacted]/18. 2. Progress Notes dated [redacted]/18 thru [redacted]18 revealed [redacted] occurred on the following dates: a. [redacted]/18: [redacted] mentioned to his nurse, [redacted] was [redacted]. b. [redacted]/18: resident's wife reported [redacted] on walk at 2 pm. c. [redacted]/18: 1:00 pm, missed chair, landed on floor. d. [redacted]/18: 11:50 am, was walking around, [redacted] e. [redacted]/18: 12:50 am, sat on arm of recliner, slipped [redacted] on floor. f. [redacted]/18: 4:00 pm, grabbed R #6 they all [redacted] to the floor, were [redacted] g. [redacted]/18: 6:45 (am/pm unknown), slid	A 025		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2043	A. BUILDING: _____ B. WING _____	C 05/03/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALL-CARE ASSISTED LIVING LLC	1001 YORK DRIVE CLOVIS, NM 88101

(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 025	Continued From page 3 onto floor, was picked up put back in chair, the Administrator walked [redacted] to [redacted] bed, [redacted]. B. Record review of R #2's resident file revealed that: 1. Resident was admitted on [redacted]17 and the initial evaluation was not completed until [redacted]/17. 2. Evaluations dated [redacted]/17 and [redacted]/18 revealed that they were not: a. Reviewed and if needed updated at a minimum of every six (6) months. b. Updated after R #2's began having [redacted] on [redacted]/17 thru [redacted]/19 3. Progress Notes dated [redacted]/17 thru [redacted]/19 revealed [redacted] occurred on the following dates: a. [redacted]/17: [redacted], checked for injuries, seemed [redacted], later [redacted], was given [redacted]. b. [redacted]/18: found on floor, all was well. c. [redacted]/19: [redacted] when walking around recliner, landed on [redacted]. d. [redacted]/19: on floor during night, [redacted], daughter called and informed that resident was [redacted]. e. [redacted]/19: daughter took to doctor then hospital. f. [redacted]/19: [redacted] C. Record Review of R #4's resident file revealed that resident was admitted [redacted]19 and the initial evaluation was not completed until [redacted]/19. D. On 05/02/18 at 10:45 pm, during an interview with the Administrator, she confirmed the findings listed above for R #s 1-2 & 4 Evaluations and Progress Notes.	A 025		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2043	A. BUILDING: _____ B. WING _____	C 05/03/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALL-CARE ASSISTED LIVING LLC	1001 YORK DRIVE CLOVIS, NM 88101

(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 026	7 NMAC 8.2.26 Individual Service Plan INDIVIDUAL SERVICE PLAN (ISP): An ISP shall be developed and implemented within ten (10) calendar days of admission for each resident residing in the facility. A. The ISP shall address those areas of need as identified in the resident evaluation and through staff observation. (1) The ISP shall detail the services that are provided by the facility as well as the services to be provided by other agencies. (2) The resident evaluation and the ISP shall be reviewed and if needed revised by a licensed practical nurse, registered nurse or a physician extender. (3) The ISP shall be reviewed and or revised at a minimum of every six (6) months or when there is a significant change in the resident ' s health status. B. The ISP shall include the following: (1) a description of identified needs as noted in the resident evaluation; (2) a written description of all services to be provided; (3) who will provide the services; (4) when or how often the services will be provided; (5) how the services will be provided; (6) where the services will be provided; (7) expected goals and outcomes of the services; (8) documentation of the facility ' s determination that it is able to meet the needs of the resident; (9) the level of assistance that the resident will require with activities of daily living and with medications; (10) a crisis prevention/intervention plan when indicated by diagnosis or behavior; and (11) current orders for all medications, including those authorized for PRN usage.	A 026		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2043	A. BUILDING: _____ B. WING _____	C 05/03/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALL-CARE ASSISTED LIVING LLC	1001 YORK DRIVE CLOVIS, NM 88101

(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 026	Continued From page 5 [7.8.2.26 NMAC - Rp, 7.8.2.26 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.26 A (3) B (10) Based on record review and interview the facility did not ensure for 2 (R #s 1 & 2) of 4 (R #s 1-4) residents whose Individual Service Plans (ISP's) were reviewed for compliance were: 1. Completed within ten (10) days of admission. 2. Reviewed and/or revised at a minimum of every six (6) months or when a change in condition occurred and the resident began having falls. This deficient practice has the potential for residents to be at risk of harm or injury if Direct Care Staff (DCS) are not providing the correct care/services needed if the ISPs were not completed upon admission, reviewed at six months or a change in condition because they do not know what the changes have been made. The findings are: A. Record review of R #1's Progress Notes dated [redacted]/18 thru [redacted]1/18 revealed [redacted] occurred on the following dates: 1. [redacted]/18 2. [redacted]/18 3. [redacted]/18 4. [redacted]/18 5. [redacted]/18 6. [redacted]/18 7. [redacted]/18	A 026		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2043	A. BUILDING: _____ B. WING _____	C 05/03/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALL-CARE ASSISTED LIVING LLC	1001 YORK DRIVE CLOVIS, NM 88101

(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 026	Continued From page 6 8. [redacted]/19 B. Record review of R #1's ISPs dated [redacted]/18 and [redacted]/18 revealed: 1. Admission on [redacted]/18. 2. Initial ISP dated [redacted]/18. 3. No updates to the ISP regarding the [redacted] documented in progress notes. C. On 05/02/19 at 10:45 pm, during an interview with the Administrator, she confirmed the findings listed above for R #s 1 & 2 ISPs and Progress Notes.	A 026		
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:	A 032		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2043	A. BUILDING: _____ B. WING _____	C 05/03/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALL-CARE ASSISTED LIVING LLC	1001 YORK DRIVE CLOVIS, NM 88101

(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 032	Continued From page 7 (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. [7.8.2.32 NMAC - Rp, 7.8.2.32 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.32 A (1) B refer to 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	A 032		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2043	A. BUILDING: _____ B. WING _____	C 05/03/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALL-CARE ASSISTED LIVING LLC	1001 YORK DRIVE CLOVIS, NM 88101

(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 032	Continued From page 8 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. Based on record request and interview, the facility failed to ensure that all incidents of alleged verbal and physical abuse towards a resident by Direct Care Staff (DCS): 1. Were reported to the Licensing Authority within twenty-four (24) hours or the next business day if a holiday or weekend. 2. An investigation/follow-up report was submitted to the Licensing Authority within five (5) business days of the incident. This deficient practice has the potential for all 6 (R #s 1-6) residents identified on the census provided by the Administrator on 04/30/19, to be at risk of harm, injury, and/or death, if there is no oversight by the Licensing Authority, because the facility failed to report incidents of alleged abuse and neglect or submit an investigation/follow-up report. The findings are: A. On 04/30/19 at 12:25 pm, during an interview, anonymous #1 (A #1) stated that "Before Christmas 2018, the Administrator was told by A #1 that DCS #1 was observed yelling at [name of resident] to sit down (resident kept getting up) and DCS #1 pushed down [name of person] on	A 032		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2043	A. BUILDING: _____ B. WING _____	C 05/03/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALL-CARE ASSISTED LIVING LLC	1001 YORK DRIVE CLOVIS, NM 88101

(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 032	Continued From page 9 to the coach, hit [name of person] when food was spat out, yells in [name of person] face when [name of person] does not finish [name of person] meals." B. On 04/30/19 at 4:40 pm, during an interview, Anonymous #2 reported to the Administrator saying that: 1. Anonymous #2 observed DCS #1 yelling in the residents faces, right close to their faces saying "Just cause you may be old but I can wreck you." 2. Anonymous #2 observed DCS #1 yelling behavior becomes louder when DC #1's actions are challenged. 3. Anonymous #2 observed DCS #1 hit [name of person] on the back when [name of person] spits food out. 4. Anonymous #2 observed DCS #1 stating DCS #1 had no problem fighting with one of Anonymous #2's residents. C. Record request for facility's internal and reportable incidents revealed no documentation for any incidents of alleged abuse and neglect reports completed by staff at the facility. D. On 05/02/19 at 10:34 am, during an interview with the Administrator, she confirmed that no incident reports were completed/submitted to the Licensing Authority. In addition, she stated that she had stopped completing incident reports at the facility.	A 032		
A 033	7 NMAC 8.2.33 Resident Rights RESIDENT RIGHTS: All licensed facilities shall understand, protect and respect the rights of all residents.	A 033		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2043	A. BUILDING: _____ B. WING _____	C 05/03/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALL-CARE ASSISTED LIVING LLC	1001 YORK DRIVE CLOVIS, NM 88101

(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 033	Continued From page 10 A. Prior to admission to a facility, a resident and legal representative shall be given a written description of the legal rights of the resident, translated into another language, if necessary, to meet the resident ' s understanding. B. If the resident has no legal representative and is incapable of understanding his or her legal rights, a written copy of the resident's legal rights shall be provided to the most significant responsible party in the following order: (1) the resident's spouse; (2) significant other; (3) any of the resident's adult children; (4) the resident's parents; (5) any relative the resident has lived with for six or more months before admission; (6) a person who has been caring for, or paying benefits on behalf of the resident; (7) a placing agency; (8) resident advocate; or (9) the ombudsman. C. The resident rights shall be posted in a conspicuous public place in the facility and shall include the telephone numbers for the incident management hotline and for the state ombudsman program. D. To protect resident rights, the facility shall: (1) treat all residents with courtesy, respect, dignity and compassion; (2) not discriminate in admission or services based on gender, sexual orientation, resident's age, race, religion, physical or mental disability, or nationality; (3) provide residents written information about all services provided by the facility and their costs and give advance written notice of any changes; (4) provide residents with a safe and sanitary living environment; (5) provide humane care for all residents;	A 033		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2043	A. BUILDING: _____ B. WING _____	C 05/03/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALL-CARE ASSISTED LIVING LLC	1001 YORK DRIVE CLOVIS, NM 88101

(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 033	Continued From page 11 (6) provide the right to privacy, including privacy during medical examinations, consultations and treatment; (7) protect the confidentiality of the resident ' s medical record; (8) protect the right to personal privacy, including privacy in personal hygiene; privacy during visits with a spouse, family member or other visitor; and privacy in the resident's own room; (9) protect the right to communicate privately and freely with any person, including private telephone conversations and private correspondence; and the right to receive visits from family, friends, lawyers, ombudsmen and community organizations; (10) prohibit the use of any and all physical and chemical restraints; (11) ensure that residents: (a) are free from physical and emotional abuse neglect and misappropriation/or exploitation; (b) are free from financial abuse and misappropriation by facility staff or management; (c) are free to participate in religious, social, community and other activities and freely associate with persons in and out of the facility; (d) are free to leave the facility and return without unreasonable restriction; (e) are given a fifteen (15) calendar day, written notice before room transfers or discharge from the facility unless there is immediate danger to self or others in the facility; (f) have an environment that fosters social interaction and avoids social isolation; (g) or their surrogate decision makers, are informed of and consent to the services provided by the facility; (h) have the right to voice grievances to the facility staff, public officials, the ombudsmen, any state agency, or any other person, without fear of	A 033		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2043	A. BUILDING: _____ B. WING _____	C 05/03/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALL-CARE ASSISTED LIVING LLC	1001 YORK DRIVE CLOVIS, NM 88101

(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 033	Continued From page 12 reprisal or retaliation; (i) have the right to have their complaints addressed within fourteen (14) calendar days or sooner; (j) have the right to participate in the development of their care plan/ISP; (k) have the right to choose a doctor, pharmacist and other health care provider(s); (l) have the right to participate in medical treatment decisions and formulate advance directives such as living wills and powers of attorney; (m) have the right to keep and use personal possessions without loss or damage; (n) have the right to manage and control their personal finances; (o) have the right to freely organize and participate in a resident association that may recommend changes in the facility's policies, services and management; (p) shall not be required to work for the facility; and (q) are protected from unjustified room transfers or discharge. E. The resident's rights shall not be restricted unless this restriction is for the health and safety of the resident, agreed to by the resident or the resident ' s surrogate decision maker and outlined in the resident ' s individual service plan. [7.8.2.33 NMAC - Rp, 7.8.2.34 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.33 D 11 (a) (l) Based on record review and interview the facility	A 033		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2043	A. BUILDING: _____ B. WING _____	C 05/03/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALL-CARE ASSISTED LIVING LLC	1001 YORK DRIVE CLOVIS, NM 88101

(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 033	Continued From page 13 failed to ensure: 1. Residents were free from alleged verbal, and physical abuse committed by Direct Care Staff (DCS) at the facility. 2. Allegations of verbal/physical abuse to the Licensing Authority within twenty-four (24) hours or the next business day if a holiday or weekend and submitting a completed investigation within five (5) business days of the incident. 3. Qualified medical personnel notification to evaluate residents who had fallen with possible injuries. 4. Residents who had fallen were assisted immediately and not neglected (remove) left on the floor. 5. Notification of the Primary Care Physician (PCP) and a designated person (family/legal representative) when falls w/injury occurred. This deficient practice has the potential for all 6 (R #s 1-6) residents identified on the census provided by DCS #1 on 04/30/19 to be at risk of harm, injury, and/or death if: 1. DCS verbally or physically abuse the residents. 2. Allegations of verbal/physical abuse go unreported to the Licensing Authority. 3. Residents do not receive medical attention when injuries occur. 4. Residents do not receive immediate assistance when falls occur, and/or 5. There is delay to necessary lifesaving medical attention. The findings are: A. On 04/30/19 at 12:25 pm, during an interview, Anonymous stated that "Before Christmas 2018, Anonymous observed DCS #1 yelling at [name of	A 033		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2043	A. BUILDING: _____ B. WING _____	C 05/03/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALL-CARE ASSISTED LIVING LLC	1001 YORK DRIVE CLOVIS, NM 88101

(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 033	Continued From page 14 person] telling [name of person] to sit down, (resident kept standing up) and pushing [name of person] down into the couch, hit [name of person] on the back when [name of person] spat his food out." B. On 04/30/19 at 4:40 pm, during an interview with Anonymous #2, stated "DCS #1 yells in the faces of the residents right close to their faces saying, "Just cause you may be old but I can wreck you." Has yelled at Anonymous #2 in front of residents saying was not doing her job and DCS #1 yelling behavior becomes louder when she is challenged by her behaviors of accusations towards staff. [Name of person] informed that DCS #1 hit [name of person] on the back because [name of person spits food] out. DCS #1 told stated that she has no problem with fighting with one of Anonymous patients (residents)." Anonymous #2 took her concerns of abuse towards residents to the Administrator and nothing was done. Anonymous #2 has witnessed the Administrator say to leave [name of person] on the floor he can get by himself up. [name of person] was unable to get up from the floor. At least 5 times a week [name of person] would help [name of person] get up off the floor at the beginning of her shift that starts at 1:30 pm. Other residents at the facility would inform Anonymous #2 that [name of person] was on the floor all morning." C. On 05/01/19 at 12:17 pm, during an interview, Anonymous #2 stated that on 03/21/19 [name of resident] [redacted] on [redacted] [redacted] Anonymous #2 asked the Administrator if should call someone like family or the EMTs (Emergency Medical Technicians) and the Administrator replied, "Not at this time".	A 033		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2043	A. BUILDING: _____ B. WING _____	C 05/03/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALL-CARE ASSISTED LIVING LLC	1001 YORK DRIVE CLOVIS, NM 88101

(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 033	Continued From page 15 D. On 05/01/19 at 4:45 pm during an interview, Anonymous #3 reported that "The Administrator did not contact Anonymous #3 for two days on 03/28/19 after the [redacted] on [redacted]/19 and stated that [name of person] has [redacted] before but this time was different. The facility was waiting for Anonymous to return. Facility did not call emergency services for [name of person] the [redacted]. Anonymous picked up [name of person] who was in a wheelchair and took them to doctor's appointment [redacted]/19. The doctor told us to take [redacted] over to the hospital for an [redacted] from the doctor's office. [Name of person] was complaining of [redacted] when trying to get [name of person] back into the car. [Name of Person] could not get into the car so [name of person] was in wheelchair and we walked to the hospital across the street. The facility did not call any other relatives." E. Record request for facility's internal and reportable incidents revealed no documentation of alleged abuse or neglect reports completed by staff at the facility. F. On 05/02/19 at 10:34 am, during an interview with the Administrator, she confirmed no incident reports, or 5-day follow-up investigation reports submitted to Licensing Authority and said facility staff had stopped completing incident reports at the facility. She also stated that no one had informed her of DCS #1's alleged verbal or physical abuse towards residents. G. Record review of R #1's Progress notes listed below revealed no documentation that a medical evaluation was provided by qualified medical personal when resident [redacted] on the following	A 033		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2043	A. BUILDING: _____ B. WING _____	C 05/03/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALL-CARE ASSISTED LIVING LLC	1001 YORK DRIVE CLOVIS, NM 88101

(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 033	Continued From page 16 dates: 1. [redacted]/18 at 1:00 pm "Missed sitting in chair, landed on floor - [redacted]." 2. [redacted]/18 at 4:00 pm "[redacted] on the floor with another resident - both were [redacted] note was not signed." 3. [redacted]/18 at 6:45, "Resident slid to floor caregiver picked [redacted] up and put [redacted] back in chair - DCS #4 and Admin walked [redacted] to his bed - [redacted] signed by Admin." 4. [redacted]/18 "Resident fell twice once hitting the floor [redacted] and at 12:50 am slipped off the recliner onto the floor." 5. [redacted]/18 "Resident was on the floor." 6. [redacted]/18 "Resident was found on the floor could not get up. Resident later got [redacted] up and then 10 minutes later resident was on the floor yelling." 7. [redacted]/18 "Resident was on the floor with [redacted] with [redacted] and [redacted] on the floor." H. Record review of Nursing Progress Record for R #1 dated [redacted]/18 (illegible signature) revealed: 1. "Resident [redacted] down" 2. Notation written on form dated "[redacted]/18 at 3:30 pm, resident on the floor - [redacted] - talking, shouting initialed by Administrator" I. Record review of R #2 Facility Progress Notes revealed no documentation of medical evaluation by qualified medical personnel (nurse, emergency medical technician) when resident [redacted] on the following dates: 1. [redacted]/17 "Resident had a [redacted], checked for injuries by DCS # 4. During dinner resident was [redacted]." 2. [redacted]/17 6:00 am: "R #2 found in another	A 033		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2043	A. BUILDING: _____ B. WING _____	C 05/03/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALL-CARE ASSISTED LIVING LLC	1001 YORK DRIVE CLOVIS, NM 88101

(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 033	Continued From page 17	A 033		

resident's closet on the floor. Seems fine; sat [redacted] in chair everything fine. Signed by DCS #5."

3. [redacted]/18 "Found on floor at 6:00 pm - all is well. Initialed by Administrator."

4. [redacted]/19 "Resident fell, but did not hit [redacted] head, but landed on [redacted] notes signed by direct care staff, (DCS) #3."

5. [redacted]/19, "Resident was on the floor during the night, sitting up on [redacted] notes initialed by Administrator."

J. On 05/02/19 at 10:35 am, during an interview, the Administrator confirmed that R #s 1 & 2 were not evaluated by Emergency Medical Technicians or by qualified medical personnel when the falls occurred.

K. Per record review of R #2's hospital medical records dated [redacted] 18 - [redacted] 18, pages 25 and 26: "Resident was bought in with complaints of [redacted] [redacted]/19. Patient was reported to have had a [redacted] about a week ago. In past few days [redacted] was noted to have [redacted]. Patient was seen at an outpatient clinic today and [redacted] were completed. Patient has a [redacted]. Patient admitted into hospital on [redacted] 19 and [redacted] for [redacted] on [redacted]/19."

Findings related to contacting PCP/family-legal repersentitive

Findings for R #1:

L. Record review of R #1's resident file revealed no documentation that the facility attempted to contact R #1's PCP or a family member to inform them of R #1's [redacted] on [redacted]/18, so they could participate in making medical treatment decisions.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2043	A. BUILDING: _____ B. WING _____	C 05/03/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALL-CARE ASSISTED LIVING LLC	1001 YORK DRIVE CLOVIS, NM 88101

(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 033	Continued From page 18 M. On 05/02/19 at 10:35 am, during an interview with the Administrator, she confirmed that no contact to PCP or family member were made following R #1's fall. Findings for R #2: N. Record review of R #2's facility Progress Notes dated [redacted]/19 [time not noted] revealed that R #2 [redacted], but landed on [redacted] notes signed by Direct Care Staff (DCS) #3. O. On 05/01/19 at 12:17 pm, during an interview with DCS #3, she stated that on [redacted]/19 between 7:00-8:00 pm, while she was trying to fix the blanket for R #2 that DCS #3 had tried to move R #2's purse out of the way, but R #2 tried to grab the purse tripped and [redacted] onto [redacted] did not [redacted] but DCS #3 heard a [redacted] R #2 complained of pain in [redacted] DCS #3 said she asked Administrator whether someone should be called about the fall and was told, No. P. On 05/01/19 at 4:40 pm, during an interview with R #2's POA, she stated she was not contacted/informed of the [redacted]/19 [redacted] at the time it occurred. Q. Record review of R #2's resident file revealed no documentation of any attempts or actual contact made with R #2's PCP or POA to report R #2's [redacted] occurring on [redacted]/19 until 03/28/19. R. On 05/02/19 at 10:35 am, during an interview with the Administrator, she confirmed that the facility did not contact R #'s POA/PCP, so they	A 033		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2043	A. BUILDING: _____ B. WING _____	C 05/03/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALL-CARE ASSISTED LIVING LLC	1001 YORK DRIVE CLOVIS, NM 88101

(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 033	Continued From page 19 could participate in her medical treatment decisions when the resident had a [redacted] and complained of [redacted] on [redacted]/19 or when previous falls had occurred.	A 033		
A 070	7 NMAC 8.2.70 Incorporated and Related Rules and Codes 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: A. Health Facility Licensure Fees and Procedures, New Mexico Department of Health, 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] This REQUIREMENT is not met as evidenced by: Based on record request and interview, the facility failed to ensure that all incidents alleged of verbal and physical abuse towards a resident by Direct Care Staff (DCS): 1. Were reported to the Licensing Authority within twenty-four (24) hours or the next business	A 070		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2043	A. BUILDING: _____ B. WING _____	C 05/03/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALL-CARE ASSISTED LIVING LLC	1001 YORK DRIVE CLOVIS, NM 88101

(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 070	Continued From page 20	A 070		

day if a holiday or weekend.
2. An investigation/follow-up report was submitted to the Licensing Authority within five (5) business days of the incident.

This deficient practice has the potential for all 6 (R #s 1-6) residents identified on the census provided by the Administrator on 04/30/19, to be at risk of harm, injury, and/or death, if there is no oversight by the Licensing Authority, because the facility failed to report incidents of alleged abuse and neglect or submit an investigation/follow-up report. The findings are:

A. On 04/30/19 at 12:25 pm, during an interview, anonymous #1 stated that "Before Christmas 2018, told Administrator that DCS #1 was observed yelling at [name of resident] to sit down (resident kept getting up) and DCS #1 pushed down [name of person] on to the coach, hit [name of person] when food was spat out, yells in [name of person] face when [name of person] does not finish [name of person] meals."

B. On 04/30/19 at 4:40 pm, during an interview, Anonymous #2, reported to administrator saying that:
1. Anonymous #2 observed DCS #1 yelling in the the residents faces, right close to their faces saying "Just cause you may be old but I can wreck you."
2. Anonymous #2 observed that DCS' #1 yelling behavior becomes louder when their actions are challenged.
3. Anonymous #2 observed DCS #1 hit [name of person] on the back when [name of person] spits food out.
4. Anonymous #2 observed DCS #1 stating they have no problem with fighting with one

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2043	A. BUILDING: _____ B. WING _____	C 05/03/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALL-CARE ASSISTED LIVING LLC	1001 YORK DRIVE CLOVIS, NM 88101

(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 070	Continued From page 21 Anonymous #2's residents. C. Record request for facility's internal and reportable incidents revealed no documentation for any incidents of alleged abuse and neglect reports completed by staff at the facility. D. On 05/02/19 at 10:34 am, during an interview with the Administrator, she confirmed that no incident reports were completed and added she stopped completing incident reports at the facility, and no staff have reported any incidents of abuse to her. 7.8.2.70 F B refer to 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	A 070		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2043	A. BUILDING: _____ B. WING _____	C 05/03/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALL-CARE ASSISTED LIVING LLC	1001 YORK DRIVE CLOVIS, NM 88101

(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 070	Continued From page 22 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 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 request and interview, the facility failed to ensure that all incidents alleged of verbal and physical abuse towards a resident by Direct Care Staff (DCS): 1. Were reported to the Licensing Authority within twenty-four (24) hours or the next business day if a holiday or weekend. 2. An investigation/follow-up report was submitted to the Licensing Authority within five (5) business days of the incident. This deficient practice has the potential for all 6 (R #s 1-6) residents identified on the census provided by the Administrator on 04/30/19, to be at risk of harm, injury, and/or death, if there is no oversight by the Licensing Authority, because the	A 070		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2043	A. BUILDING: _____ B. WING _____	C 05/03/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALL-CARE ASSISTED LIVING LLC	1001 YORK DRIVE CLOVIS, NM 88101

(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 070	Continued From page 23 facility failed to report incidents of alleged abuse and neglect or submit an investigation/follow-up report. The findings are: A. On 04/30/19 at 12:25 pm, during an interview, anonymous #1 stated that before Christmas 2018, told Administrator that DCS #1 was observed yelling at [name of resident] to sit down (resident kept getting up) and DCS #1 pushed down [name of person] on to the coach, hit [name of person] when food was spat out, yells in [name of person] face when [name of person] does not finish [name of person] meals. B. On 04/30/19 at 4:40 pm, during an interview, Anonymous #2, reported to administrator saying that: 1. Anonymous #2 observed DCS #1 yelling in the the residents faces, right close to their faces saying "Just cause you may be old but I can wreck you." 2. Anonymous #2 observed that DCS' #1 yelling behavior becomes louder when their actions are challenged. 3. Anonymous #2 observed DCS #1 hit [name of person] on the back when [name of person] spits food out. 4. Anonymous #2 observed DCS #1 stating they have no problem with fighting with one Anonymous #2's residents. C. Record request for facility's internal and reportable incidents revealed no documentation for any incidents of alleged abuse and neglect reports completed by staff at the facility. D. On 05/02/19 at 10:34 am, during an interview with the Administrator, she confirmed that no incident reports were completed and added she	A 070		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2043	A. BUILDING: _____ B. WING _____	C 05/03/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALL-CARE ASSISTED LIVING LLC	**1001 YORK DRIVE CLOVIS, NM 88101**

(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 070	Continued From page 24 stopped completing incident reports at the facility, and no staff have reported any incidents of abuse to her.	A 070		