Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	5605	A. BUILDING: _____ B. WING _____	C 10/07/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGHPOINTE CARE, INC	6001 ROGERS DRIVE NE ALBUQUERQUE, NM 87110

(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 as a result of a complaint investigation survey on 10/07/13 for the Requirements for Adult Residential Care Facilities NMAC 7.8.2 . Complaint #NM29225 was Substantiated with deficiencies. Complaint #NM28988 was Substantiated with deficiencies.	A 000		
A 021	7 NMAC 8.2.21 Resident Records RESIDENT RECORDS: A. Record contents. A record for each resident shall be maintained in accordance with the specific requirements of this section. Entries in each resident's record shall be legible, dated and authenticated by the signature of the person making the entry. Resident records shall be readily available on site and organized utilizing a table of contents. Each resident record shall include: (1) the admission agreement records, as set forth in 7.8.2.20 NMAC; (2) the resident evaluation form, that is to be completed within fifteen (15) days prior to admission and updated at a minimum of every six (6) months; (3) the current ISP, that is to be completed within ten (10) calendar days of admission and updated at a minimum of every six (6) months; (4) the physical examination report; the physical examination report shall have been completed within the past six (6) months, by a primary care physician, a nurse practitioner or a physician ' s assistant and shall be on file in the resident ' s record within ten (10) days of admission; (5) personal and demographic information for the	A 021	Scanned 12/26/13 KH RECEIVED DEC 13 2013 HEALTH FACILITY LICENSING & CERTIFICATION BUREAU RECEIVED DEC 13 2013 HEALTH FACILITY LICENSING & CERTIFICATION BUREAU	

Division of Health Improvement
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE: 12-12-13

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A 021	Continued From page 1 resident, to include: (a) current names, addresses, relationship and phone numbers of family members, or surrogate decision makers updated as necessary; (b) resident's name; (c) age; (d) recent photograph; (e) marital status; (f) date of birth; (g) sex; (h) address prior to admission; (i) religion (optional); (j) personal physician; (k) dentist; (l) social history; (m) surrogate decision maker or other emergency contact person; (n) language spoken and understood; (o) legal documentation relevant to commitment or guardianship status; (p) current medications list; and (q) required diet; (6) unless included in the admission agreement, a separate written agreement between the facility and the resident relating to the resident's funds, in accordance with the facility's policy and procedures; (7) entries by direct care staff, appropriate health care professionals and others authorized to care for the resident; entries shall be dated and signed by the person making the entry and shall include significant information related to the ISP; (8) entries that provide a written account of all accidents, injuries, illnesses, medical and dental appointments, any problems or improvements observed in the resident, any condition that would indicate a need for alternative placement or medical attention and entries reflecting appropriate follow-up; the maintenance of such	A 021		

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A 021	Continued From page 2	A 021		

written documentation in the resident record may be by copy of an incident or accident report, if the original incident or accident report is maintained elsewhere by the facility;
(9) the medication assistance record (MAR); the MAR is the document that details the resident's medication; the MAR shall include all of the information pursuant to Subsection G of 7.8.2.35 NMAC of this rule;
(10) progress notes completed by any contract agency (e.g., hospice, home health); the progress notes shall include the date, time and type of health services provided;
(11) copies of all completed and signed transfer forms from the accepting facility when a resident is transferred to a hospital or another health care facility and when the resident is transferred back to the facility; and
(12) upon the death or transfer of a resident, documentation of the disposition of the resident's personal effects and money or valuables that are deposited with the assisted living facility.
B. Resident records maintenance.
(1) Current resident records shall be maintained on-site and stored in an organized, accessible and permanent manner.
(2) The facility shall establish a policy to maintain and ensure the confidentiality of resident records, including the authorized release of information from the resident records.
(3) Non-current resident records shall be maintained by the facility against loss, destruction and unauthorized use for a period of not less than five (5) years from the date of discharge and readily available within twenty-four (24) hours of request.
(4) There shall be a policy and procedure in place for record retention in the event of facility closure.
(5) Failure to follow facility policies is grounds for

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A 021	Continued From page 3 sanctions. [7.8.2.21 NMAC - Rp, 7.8.2.22 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to include documentation in the resident's chart related to falls, injuries and the cause of the fall for 2 (#s 3 and 6) of 10 (#s 1, 2, 3, 4, 5, 6, 7, 8, 9,10) sampled residents. This deficient practice has the potential to impede effective communication among staff members and prevent further fall interventions and/or strategies. The findings are: A. During review of Resident #6's medical record, there were no entries related to the fall on 02/18/13. 1. During review of a complaint intake dated 02/18/13 it was noted that the resident fell at 6:30 am. Staff #1 found the resident on the floor with blood on her forehead. B. During review of Resident #3's medical record, there were no entries related to the fall on 08/20/13. 1. On 10/07/13 at 2:45 pm, during observation of the facility residents, Resident #3 was observed with a black eye. C. On 10/7/13 at 4:15 pm during interview with the owner/administrator, she stated that staff does not make notations in residents' charts regarding health care issues or events that take place. She also stated that a written log of resident events is not maintained.	A 021	Deficiency A021 Resident Records 7.8.2.21 All internal as well as state reportable incidents are placed by the month in the "Rogers Incident Report 2013" binder and are fully reviewed and resolved. The existing binder labeled Rogers Incident Report 2013 is kept in the office and was present on the day of the survey. This book has been existence every year that we have been in operation The Administrator misunderstood the question asked of her by the surveyor with regard to communication between the staff regarding resident incidents. The Administrator said she does not find value in a "communication log" between the staff. This in no way should have been interpreted to mean that nothing is charted on resident incidents. All resident files will contain an additional tab labeled Incidents. The staff will be instructed to file a resident incident within the resident binder. This plan of correction will be completed no later than 12-25-13. The Administrator will immediately correct the documentation procedure for each shift. Beginning 12-25-13, every resident will have a journal kept in their resident binder. Every shift will report resident progress notes in the resident journal to include illness of any sort and what steps were taken to have a satisfactory outcome. Further, at shift change report, staff members will review and discuss end of shift notes to familiarize themselves with the previous shift occurrences. Communication strategies and interventions will be sought to achieve safe resident health outcomes.	

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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. 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	A 033		

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A 033	Continued From page 5 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; (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	A 033		

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A 033	Continued From page 6 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 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: This deficiency refers to 7.8.2.33.11.a	A 033	A033 Resident Rights 7.8.2.33.11 a As the Administrator of this home, I was appalled by the actions of my former employee who should be sanctioned for her actions for leaving her post for 15-20 min. At a minimum she should not be allowed to pass the Criminal History Screening as a caregiver in the future. I wanted her reported to the Incident Management Bureau for consideration by the State Caregiver's Registry to remove her ability to work in this field because of her actions. It was also my duty to report this incident through the Incident Management Bureau. It is not this company's practice to leave our residents unattended at any time. The former employee was terminated for her actions. It should be noted for the record that the primary caregiver/cook and supervisor that responded immediately to this incident were extremely concerned for the residents and remedied the situation immediately. It is our current policy to drop in unannounced at different times of the day including the evenings to spot check the supervision of our staff. We also use continuous video monitoring for quality assurance. On this evening, the MAR manager was making a spot check and recognized that the caregiver was not present, though her coat, purse and other belongings were present. Immediately the manager called the Administrator and secured additional staff to arrive within 5 minutes. To further enhance the safety and security of our residents, we will immediately begin the requirement of staff person on duty leaving messages on the manager's phone at various times of the night as designated on a schedule of randomized hours. The manager will review these	

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A 033	Continued From page 7 Based on record review and interview, the facility failed to ensure that 10 of 10 (1, 2, 3, 4, 5, 6, 7, 8, 9, 10) residents were not left unattended for any length of time. This deficient practice has the potential to affect the safety and well being of the residents by leaving them with no staff supervision. The findings are: A. On 10/07/13 at 3:00 pm during interview with the Administrator, she stated that at on the day that the Former Employee left the facility due to her car being broken into, the. The Medication Administration Record (MAR) Manager arrived at the facility, and when she saw that there was no staff member present, the MAR Manager notified the Administrator that the Former Employee had left the facility. At that time, the Cook was called in by the Administrator to the facility and they arrived within fifteen minutes. B. On 10/07/13 at 4:06 pm during interview with the Former Employee involved in complaint, she stated that at about 9:00 pm or a few minutes after, she was cleaning and taking out the trash and she "heard something" but didn't see anything. After emptying the trash, she was going to move her car into the driveway. She stated that another employee, the cook (Employee #2) told her that she couldn't park in the driveway during business hours because this was for emergencies only. She also stated that "I have to manually lock the car because my key fob doesn't work." When she went out a few minutes after taking out the trash to move her car, she saw that there was a man outside next to the car and she thought that she heard breaking glass and the back passenger door was open. "I yelled at him and he took off running so I jumped in my car and chased him through the	A 033	times to insure that the staff made the calls from the home's telephone at the designated hours. Failure to do so will be cause for dismissal. Additionally, a new policy will be implemented that will require all staff to perform non-resident duties in front of the camera surveillance system, such as cooking, cleaning, charting and medication assistance. This system will enhance the security of knowing the staff are on premises at all times.	

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neighborhood but I couldn't find him. I went back to the house after being gone for maybe 15 or 20 minutes." Stated that she called the police when she was on her way back to the house. Stated that at the time that she left the house to chase after the man, there was no other staff on site, she was the only Caregiver scheduled to work that night. Her shift was 7:00 pm - 7:00 am.
The Former Employee stated that when she arrived back at the house, the MAR Manager was there (wasn't there when she left to follow the person she thought broke into her vehicle). Stated that the MAR Manager wanted to see the car window (which ended up not being broken).
The Former Employee stated that a stereo was stolen out of her vehicle. Former Employee stated that about 15 minutes after she arrived back at the house, the Cook had arrived to the facility after having been called in by the Administrator. Former Employee stated that the MAR Manager called the Administrator and told her that Former Employee was lying. The Former Employee stated that after an argument about the incident between herself and the MAR Manager, she left the building. She stated that she left the facility before the police arrived.
Former Employee stated that she spoke with the Administrative Assistant about 5 or 6 days later by phone and she was terminated at that time.

C. On 10/01/13 at 4:46 pm during interview with the facility Cook, she stated that on the day of the incident, the Administrator called her and notified her about what happened with the Former Employee leaving the facility and asked her to come to the facility. The Cook stated that she arrived at the facility at about 9:25 pm and the Former Employee and the MAR Manager were here. When she arrived at the facility, she asked the Former Employee what happened. The

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A 033	Continued From page 9 Former Employee told her that somebody broke into her car. The Cook stated that she is not sure exactly how long the residents were left unattended. She stated that by the time the police officers came to the facility, the employee had already gone. Stated that the Former Employee left after having argued with the MAR Manager about the incident. The Cook stated that she stayed at the facility for the rest of the night and left at about 5:00 am. D. Review of Employment File indicates Termination of Employment documentation dated 09/03/13 stating that the employee was terminated due to abandonment of job duties. This deficiency refers to 7.8.2.33.10 Based on observation, the facility failed to ensure that residents are free of physical restraints for 3 (#s 3, 5 and 6) of 10 (1, 2, 3, 4, 5, 6, 7, 8, 9 and 10) residents. The findings are: A. On 10/07/13 at 2:56 pm, during observation of Resident #6's room, the bed was found to have a 3/4 bedrail on one side of the bed, centrally located, with the other side of the bed against the wall. B. On 10/07/13 at 3:00 pm, resident #5 was observed lying in bed with both side rails raised. The rails were 3/4 length, and centrally located on the bed. C. On 10/07/13 at 3:03 pm, during observation of resident #3's bed, 3/4 length side rails were found on both sides of the bed, in the down position.	A 033	A033 7.8.2.33.10 Bedrails were in use as a safety measure for the residents who could potentially fall out of bed. The visiting physicians have given permission for their patients to use a bedrail. Additionally, the bedrails are especially designed to prevent injury. The plan of correction will be to use alternate measures to maintain the safety of our residents while they are in bed to include bed alarms, fall mats, and low beds. The purpose of the rails were specifically for resident safety while sleeping never for use as a restraint. The completion date for the removal of the bedrails will be no later than 12-25-13. With all due respect, resident #3s bedrail is a ½ length, not ¾.	

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