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FORM APPROVED

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 5605	(X2) MULTIPLE CONSTRUCTION HEALTH FACILITY LICENSING & CERTIFICATION BUREAU A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R-C 01/16/2014
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NAME OF PROVIDER OR SUPPLIER HIGHPOINTE CARE, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 6001 ROGERS DRIVE NE ALBUQUERQUE, NM 87110
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{A 000}	Initial Comments The following deficiencies were cited as a result of a revisit survey on 01/16/14 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}	<p><i>Reviewed 5/2/14 [Signature]</i></p>	

Division of Health Improvement
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

[Handwritten Signature]

TITLE

Director

(X8) DATE

4-25-14

Division of Health Improvement

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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}	<p>Continued From page 2</p> <p>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;</p> <p>(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;</p> <p>(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;</p> <p>(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</p> <p>(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.</p> <p>B. Resident records maintenance.</p> <p>(1) Current resident records shall be maintained on-site and stored in an organized, accessible and permanent manner.</p> <p>(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.</p> <p>(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.</p> <p>(4) There shall be a policy and procedure in place for record retention in the event of facility closure.</p> <p>(5) Failure to follow facility policies is grounds for</p>	{A 021}		

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{A 021}	<p>Continued From page 3</p> <p>sanctions. [7.8.2.21 NMAC - Rp, 7.8.2.22 NMAC, 01/15/2010]</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to include documentation in the residents' charts 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 and 10). This deficient practice has the potential to affect 10 residents by impeding effective communication among staff members and preventing further interventions and strategies. The findings are:</p> <p>A. During review of Resident #6's medical record, there were no entries related to the fall on 02/18/13. There was no documentation to indicate that staff were completing end of shift reports on a daily basis.</p> <p>B. During review of Resident #3's medical record, there were no entries related to the fall on 08/20/13. No documentation to indicate that staff were completing end of shift reports on a daily basis.</p> <p>1. On 10/07/13 at 2:45 pm during observation of the facility's residents, Resident #3 was observed to have a black eye.</p> <p>2. During review of the resident's medical record no documentation was found to indicate how the injury occurred.</p> <p>C. During review of the facility's plan of correction dated 12/12/13, the administrator noted that she would be in compliance with the regulation dealing with residents' records by</p>	{A 021}	<p>Deficiency A021 Resident Records 7.8.2.21</p> <p>This violation will be corrected by including in each resident's chart a daily log and progress report completed at shift's end. The progress report will include illness of any sort and what steps were taken to have a satisfactory outcome.</p> <p>This plan of correction has already been implemented as of January 16, 2014. Staff has been trained and is being monitored on this duty.</p>	

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{A 021}	<p>Continued From page 4</p> <p>12/25/13.</p> <p>D. During review of the Residents #s 3, 5 and 6, there was no documentation to indicate that a journal for each resident had been created to include "illness of any sort and what steps were taken to have a satisfactory outcome" and kept in their charts.</p> <p>E. On 01/16/14 at 2:20 pm, during interview with the owner/administrator, she stated that she stated that she preferred her established system of documentation and didn't care if the licensing agency felt changes were warranted. She also stated that the plan of correction was only to satisfy "the state" and that she had never intended to implement it.</p> <p>F. During review of the resident's medical records the following was noted:</p> <ol style="list-style-type: none"> 1. Resident #3's medical record, had no documentation to indicate that staff were completing end of shift reports on a daily basis. 2. Resident #5's medical record, had no documentation to indicate that staff were completing end of shift reports on a daily basis. 3. Resident #6's medical record, had no documentation to indicate that staff were completing end of shift reports on a daily basis. 	{A 021}		
{A 033}	<p>7 NMAC 8.2.33 Resident Rights</p> <p>RESIDENT RIGHTS: All licensed facilities shall understand, protect and respect the rights of all residents.</p> <p>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</p>	{A 033}		

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{A 033}	Continued From page 5 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; (6) provide the right to privacy, including privacy during medical examinations, consultations and treatment; (7) protect the confidentiality of the resident ' s	{A 033}		

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{A 033}	Continued From page 6 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 reprisal or retaliation; (i) have the right to have their complaints addressed within fourteen (14) calendar days or sooner;	{A 033}		

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{A 033}	<p>Continued From page 7</p> <p>(j) have the right to participate in the development of their care plan/ISP;</p> <p>(k) have the right to choose a doctor, pharmacist and other health care provider(s);</p> <p>(l) have the right to participate in medical treatment decisions and formulate advance directives such as living wills and powers of attorney;</p> <p>(m) have the right to keep and use personal possessions without loss or damage;</p> <p>(n) have the right to manage and control their personal finances;</p> <p>(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> <p>(p) shall not be required to work for the facility; and</p> <p>(q) are protected from unjustified room transfers or discharge.</p> <p>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]</p> <p>This REQUIREMENT is not met as evidenced by: This deficiency refers to 7.8.2.33.11.a</p> <p>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:</p>	{A 033}	<p>Deficiency A033 Resident's Rights 7.8.2..33.11a</p> <p>This deficiency will be corrected by ensuring all staff are aware of and trained in Resident Rights, particularly, the abandonment issue. The former employee who committed the crime of abandonment was terminated for her actions as noted in the interview comments. All staff will be instructed on the abandonment issue and that they would be committing a crime by leaving the residences unattended at any time while they are on shift.</p>	

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{A 033}	<p>Continued From page 8</p> <p>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 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.</p> <p>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 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</p>	{A 033}	<p>The Plan of Correction on this item is to conduct a training session for all current staff on abandonment and obtain their signature on a notarized affidavit acknowledging their attendance and that they understand. All future new hires will receive this instruction as part of their orientation.</p> <p>This plan of correction was implemented on 9/9/13 and again on 3/27/14.</p>	

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{A 033}	<p>Continued From page 9</p> <p>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.</p> <p>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 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</p>	{A 033}		

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{A 033}	<p>Continued From page 10</p> <p>that she stayed at the facility for the rest of the night and left at about 5:00 am.</p> <p>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.</p> <p>E. On 01/16/14 at 2:16 pm, when the administrator was asked about the staff performing duties in front of the camera as stated in the plan of correction, she stated that the camera system was not functioning at this time. "We don't know who disconnected it (the camera system) but I have the ticket in to CenturyLink."</p> <p>F. On 01/16/14 at 2:20 pm during interview with the administrator, she stated that there was no documentation available to indicate that she had conducted random visits to the facility during the night shift. These unannounced visits were to be implemented as part of her "Plan of Correction."</p> <p>G. When asked about whether the staff was calling to the Administrator's phone, she stated that this was being done but was unable to provide documentation of this and stated that "it is in my phone." She also stated that the 9:00 pm staff member must call in before 12:00 am. This deficiency refers to 7.8.2.33.10</p> <p>Based on observation and interview the facility failed to ensure that residents are free of physical restraints for 6 (#s 3, 4, 5, 8, 9 and 10) of 10 (1, 2, 3, 4, 5, 6, 7, 8, 9 and 10) residents. The findings are:</p> <p>A. On 10/07/13 at 2:56 pm, during observation of Resident #6's room the bed was found to have 3/4 length bed rails on one side of the bed</p>	{A 033}	<p>Violations pertaining to bedrails. We have been following State regulation regarding restraints found at Title 7 Chapter 8 Part 2 7.8.7 BP "Restraints." Restraints is defined as the use of full bedrails or over medication. Full bedrails have never been used at this facility and we have never been in violation of this State statute. However, the bedrails have been removed. Doing so has resulted in extreme inconvenience for some of our residents who have difficulty repositioning themselves without the use of a quarter bedrail.</p> <p>This correction has already been implemented as of 1/16/14.</p>	

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{A 033}	<p>Continued From page 11</p> <p>centrally located with the other side of the bed against the wall.</p> <p>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 quarter rails and centrally located on the bed.</p> <p>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.</p> <p>D. On 01/16/14 at 2:06 pm, during observation of the residents' rooms, six residents were found to have bed rails on their beds.</p> <ol style="list-style-type: none"> 1. At 2:14 pm, during observation of Resident #5's bed there were quarter rails on both sides of the bed. 2. At 2:15 pm, during observation of Resident #3's bed there were quarter rails on both sides of the bed. 3. At 2:17 pm, during observation of Resident #9's bed there was a quarter rail situated in the middle of the bed on one side. The other side of the bed was up against the wall. 4. At 2:18 pm during observation of Resident #4's bed there was a quarter rail on one side of the bed. The other side of the bed was up against the wall. 5. At 2:20 pm during observation of Resident #10's bed there was a quarter rail on one side of the bed. The other side of the bed was up against the wall. 6. At 2:22 pm, during observation of Resident #8's bed there were 1/4 rails on both sides of the bed. <p>E. On 01/16/14 at 2:30 pm, when asked asked about the use of siderails, the Administrator</p>	{A 033}		

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 5606	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R-C 01/16/2014
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NAME OF PROVIDER OR SUPPLIER HIGHPOINTE CARE, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 6001 ROGERS DRIVE NE ALBUQUERQUE, NM 87110
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(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 stated that it was her understanding that the residents could have siderails if they had a physician's order.	{A 033}		