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	2214	A. BUILDING: _____ B. WING _____	C 02/13/2014

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A 000	Initial Comments A complaint investigation was completed for intake NM00029336 on 02/13/14 for the state requirements of 7 NMAC 8.2, Regulations for Assisted Living. The Complaint was substantiated with deficiencies cited.	A 000		
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: (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,	A 032		

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A 032	Continued From page 1 01/15/2010] This REQUIREMENT is not met as evidenced by: Based on observation, record review and interviews, the facility failed to report incidents of resident abuse and neglect to the Licensing authority which resulted in 6 (R #1, 2, 3, 4, 6, and 7) of 6 cognitively impaired residents (who required assistance from staff for all Activities of Daily Living (ADLs) either being pulled by the arms when transferring, rough handling, left in the bathroom, feeling belittled, yelled at, and talked to in a demeaning way by a Caregiver. This deficient practice has the potential to affect the health, safety, and welfare of residents in the facility by being afraid of staff. The findings are: Resident #1 A. Record review for Resident #1 revealed the following: 1. A Department of Health (HFL&C) incident report dated 01/14/14 indicated an incident of abuse involving Caregiver #1 and Resident #1 took place. This incident report indicated that the abuse occurred on 01/02/14 and "Was not brought to the attention of the Administrator until 01/13/14." (This was twelve days after the incident occurred). 2. A written statement dated 01/14/14 from Employee #1 (who was a direct witness) indicated the following: "On 01/02/14 (name of Caregiver #1) went to lift a resident (who was identified as Resident #1) that is a total lift and just pulled [redacted] forward by [redacted] arms to lift [redacted] The resident said "No" as it did hurt [redacted] The resident was clearly upset." The written statement also indicated, "On	A 032		

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A 032	Continued From page 2 01/06/14, she (referring to Caregiver #1) took that same resident (referring to Resident #1) to the bathroom...and the caregiver left [redacted] in the bathroom and didn't go get [redacted] (referring to Resident #1) said (Name of Caregiver #1) said she was 'Just going to leave [redacted] there all night' and (name of Caregiver #1) did nothing to calm [redacted] down and comfort [redacted] she (Caregiver #1) said [redacted] (Resident #1) was 'Just a baby cry.'" 3. Face Sheet (no date) indicated Resident #1 was on Hospice as well as used a wheelchair. 4. Nursing Assessment dated 07/24/13, indicated the resident had [redacted] signs of [redacted] It further indicated the resident has signs of transferring issues from [redacted] 5. Individual Service Plan (ISP) dated 07/28/13, indicated the resident required a one person assist for transfers, has very limited ambulation as well as needing total assistance from staff for bathing, and cannot move her wheelchair by herself. B. Interviews for Resident #1 revealed the following: 1. On 02/13/14 at 8:40 am, during interview both Administrators stated, "With the incident that occurred on 01/02/14 with (name of Resident #1), she (the resident) would not have been able to tell you what happened due to [redacted] But, it would be my expectation that my staff should never pull someone by their arms, what so ever. Pulling them by their arms was a rough transfer. [redacted] would not have been able stand or pivot on [redacted] own, or understand when staff were transferring [redacted] My expectation would have been that we as the Administrators be notified	A 032		

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immediately but that didn't happen. We were not notified [redacted] (resident #1) was in fact a two person assist at times, and (name of Caregiver #1) was 'Rushing [redacted] There was some swelling on [redacted] (Resident #1) arm in relation to the incident with Caregiver #1 on 01/02/14."

2. On 02/13/14 at 10:20 am, during interview, Employee #1 stated, "I witnessed her (referring to Caregiver #1) taking (name of Resident #1) to the bathroom and she just left [redacted] there. The buzzer (referring to the call light) was going off and she (Caregiver #1) was ignoring [redacted] The resident was in tears and she said (name of Caregiver #1) said she was going to leave [redacted] in there. [redacted] is a total transfer. I had never seen (name of Resident #1) cry like that. Another time, she (referring to Caregiver #1) was getting (name of Resident #1) out of [redacted] wheelchair and she just pulled [redacted] by [redacted] arms. I witnessed this. After this incident with (name of Resident #1) occurred, I thought if she (Caregiver #1) was left alone with a resident, she would probably hurt them." Employee #1 then stated, "I had enough of her mistreating and mishandling the residents. When I saw for myself that she was capable of hurting someone is when I finally told someone."

Resident #2

C. Observation made on 02/13/14 at 12:00 pm, of Resident #2 revealed the resident to be [redacted]

D. Record review for Resident #2 revealed the following:

1. A Department of Health (HFL&C) incident report dated 01/14/14 indicated an incident of abuse involving Caregiver #1 and Resident #2 took place. This incident report indicated that the abuse occurred on 12/23/13, and "Was not

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brought to the attention of the Administrator until 01/13/14." (This was twenty two days after the incident occurred).

2. A written statement dated 01/14/14 from Employee #1 (who was a direct witness) indicated the following: "On 12/24/13, I saw and heard (name of Caregiver #1) talk badly and be little (name of Resident #2) as [redacted] was trying to walk into the kitchen...At the time, (name of Resident #2) had a [redacted] and (name of Caregiver #1) told [redacted] 'No-one wanted [redacted] in there touching things because of the nasty [redacted] had and to go sit down.' I could tell by the look on (name of Resident #2) face, [redacted] feelings had been hurt."

3. Face Sheet (no date) indicated Resident #2 had diagnoses to include [redacted]

4. Nursing Assessment dated 12/04/13, indicated the resident ambulates (walks independently), sometimes uses a cane, and wanders. It further indicated [redacted] has signs of [redacted]

5. ISP dated 12/04/13 indicated the resident requires minimal assistance from staff with Mobility and needs frequent reminders to use [redacted] cane.

E. Interviews for Resident #2 revealed the following:

1. On 02/13/14 at 8:40 am, during interview both Administrators stated, "On December 24th, all I can tell you about this incident is that it was not reported to us until we returned from vacation in January. My expectation would have been that we would be notified immediately with something like this, but that didn't happen. We were not notified. Anyone who talks to any of our residents in that way is just not ok. Regardless if they have

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[redacted] With (name of Resident #2), [redacted] has [redacted]

2. On 02/13/14 at 10:00 am, during interview House Manager #1 stated, "On January 7th, (name of Employee #1) told me that she witnessed (Caregiver #1) grab (name of Resident #2) and tell [redacted] to sit down because of the [redacted] in [redacted] was gross and 'I've told you to sit down.' Prior to this, the House Manager stated that she was not being made aware of this incident that occurred on 12/24/13.

3. On 02/13/14 at 10:20 am, during interview Employee #1 stated, "With (name of Resident #2) [redacted] had a [redacted] was walking into the kitchen and (name of Caregiver #1) told [redacted] 'Get out of the kitchen. It is nasty.' I could tell by the reaction on [redacted] (resident #2) face it hurt [redacted]

4. On 02/13/14 at 10:55 am, during interview, House Manager #2 stated, "I was made aware on January 7th from (name of Employee #1) that resident #2 had a [redacted] (Name of Caregiver #1) was screaming for [redacted] (the resident) to get out of the kitchen."

Resident #3
F. Observation made on 02/13/14 at 11:40 am, of Resident #3 revealed the resident to be laying in bed.

G. Record review for Resident #3 revealed the following:

1. A facility Investigation Report dated 01/16/14, indicated, "On the end of shift on 01/07/14, one resident (identified as Resident #4) was helping (name of Resident #3) down the hall to [redacted] room and (name of Caregiver #1) told (name of Resident #4) 'Not to help [redacted] (Name of Resident #3) became very upset and asked

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A 032	Continued From page 6 (name of Caregiver #1) not to belittle [redacted] because [redacted] is not a child." 2. Face Sheet (no date) indicated diagnoses to include [redacted] 3. Nursing Assessment dated 07/05/13, indicated the resident is able to communicate verbally, and [redacted] It further indicated the resident uses a wheelchair and has mobility issues requiring moderate assistance from staff due to [redacted] has transferring issues from a [redacted] 4. ISP dated 09/29/13, indicated the resident is unable to ambulate without assistance from staff. H. Interviews for Resident #3 revealed the following: 1. On 02/13/14, at 8:40 am, during interview, both Administrators stated, "With (name of Resident #3) there had been an incident with (Name of Caregiver #1) scolding residents #3 and #4 and we apologized to [redacted] (resident #3) for what happened. [redacted] said [redacted] was very upset about it and didn't want to work with (Name of Caregiver #1) again. [redacted] is able to verbalize [redacted] needs." 2. On 02/13/14, at 9:45 am, during interview, both Administrators stated, (Name of Resident #3) needs physical assistance with [redacted] wheelchair. [redacted] is a two person transfer and can't bear any weight on [redacted] 3. On 02/13/14, at 10:00 am, House Manager #1 stated, "On the night of January 7th, (name of Employee #1) reported to me that there was an Incident (unknown of the date) involving residents #3 and #4. Resident #4 was helping push Resident #3 in [redacted] wheelchair to [redacted] room and (Name of Caregiver #1) yelled at (name of	A 032		

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Resident #3) and said 'Why should you even ask [redacted] to help you anyway. [redacted] is sick too.'" The House Manager then stated, "(name of Resident #3) told (Name of Caregiver #1) 'Please don't be little me, I'm not a child and how upset [redacted] was.' The house manager stated, "In my mind it seemed like she (the caregiver) attempted to isolate (name of Resident #3). I believe she was trying to threaten [redacted] with isolation. The next morning when I came in, (name of Resident #3) was very upset and said that (name of Caregiver #1) had be little [redacted] was not nice to [redacted] and this was not a nice way to even talk to children." The House Manager indicated that this incident had never been reported to her when it occurred as it should have been."

4. On 02/13/14, at 10:55 am, during interview, House Manager #2 stated, "On January 7th, I was made aware of an incident between Resident #3 and #4. (Name of Resident #3) told me, 'I never talked to my kids this way, why should we be talked to like kids.'" The House Manager then stated, [redacted] (the resident) was upset about the situation and was scared of a backlash from (Name of Caregiver #1) but both residents didn't want to say anything to cause trouble."

Resident #4

I. Observation made on 02/13/14 at 11:25 am, of Resident #4 revealed the resident to be in a wheelchair and able to make [redacted] needs known.

J. Record review for Resident #4 revealed the following:

1. A facility Investigation Report dated 01/16/14 indicated, "On the end of shift on 01/07/14 one resident (identified as Resident #4) was helping (name of Resident #3) down the hall to [redacted] room and (name of Caregiver #1) told

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(name of Resident #4) [redacted] (Name of Resident #3) became very upset and asked (name of Caregiver #1) not to belittle [redacted] because [redacted] is not a child. (Name of Caregiver #1) told (name of Resident #3) when [redacted] calmed down, she would come help [redacted] and closed the door and left the room."

2. Face Sheet (no date) indicated diagnoses to include Pain and Muscle Stiffness.

3. Nursing Assessment dated 12/05/13, indicated no signs of [redacted] It indicated [redacted] has signs of mobility issues to include poor gait, [redacted] and requires minimal assistance from staff, also has transferring issues requiring minimal assistance for [redacted]

4. ISP dated 12/05/13, indicated he uses a wheelchair for mobility.

K. Interviews for Resident #4 revealed the following:

1. On 02/13/14 at 8:40 am, during interview, both Administrators indicated that they were not made aware of the incident which occurred between Caregiver #1 and Residents #3 and 4.

2. On 02/13/14, at 10:00 am, House Manager #1 stated, "On the night of January 7th, (name of Employee #1) reported to me that there was an Incident (unknown of the date) involving residents #3 and #4. Resident #4 was helping push Resident #3 in [redacted] wheelchair to [redacted] room and (Name of Caregiver #1) yelled at (name of Resident #3) and said 'Why should you even ask [redacted] to help you anyway. [redacted] is sick too. Don't do it again.'" The House Manager indicated that this incident had never been reported to her when it occurred as it should have been."

3. On 02/13/14, at 10:55 am, during interview, House Manager #2 stated, "On January 7th, I was made aware of an incident between

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A 032	Continued From page 9 Resident #3 and #4. (Name of Resident #3) told me, 'I never talked to my kids this way, why should we be talked to like kids.'" The House Manager then stated, [redacted] was upset about the situation and [redacted] was of a backlash from (Name of Caregiver #1) but both residents didn't want to say anything to cause trouble." 4. On 02/13/14, at 11:25 am, during interview Resident #4 stated, "There was one incident (referring to Caregiver #1). She (the caregiver) has a dominate side, she seemed to take over the kitchen. During the interview, regarding Caregiver #1, the resident was observed to constrict both arms together and held them crossed in place and said, "I have nothing else to say about it." Resident #6 L. Observation made on 02/13/14 at 11:50 am, of Resident #6 revealed the resident was alert, oriented and interviewable. M. Record review for Resident #6 revealed the following: 1. A facility Investigation Report dated 01/16/14, indicated there had been some concerns brought to the Administrators attention regarding Caregiver #1 of spitting in the trash and Resident #6 felt it was disrespectful. 2. Face sheet (no date) indicated diagnoses to include [redacted] 3. Nursing Assessment dated 10/07/13, indicated the resident has signs of [redacted] 4. ISP dated 10/07/13, indicated, [redacted] uses a wheelchair and is a high fall risk. N. Interviews for Resident #6 revealed the following:	A 032		

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A 032	Continued From page 10 1. On 02/13/14 at 11:50 am, during interview Resident #6 stated, "I disliked everything about her (referring to Caregiver #1) and "She was the worst one ever that was working here. She was very rough with patients. To assist someone, she would grab the residents. Other girls (referring to staff) would try say to Caregiver #1 ways to correct her. When putting dishes away, she was coughing in her hand and continued to put the dishes away. I avoided her once or twice. I would hate to see her come back and would not even want her to help me. There is an unpleasantness about her." 2. On 02/13/14 at 8:40 am, during interview, both Administrators stated, "One resident (referring to Resident #6) told me she (Caregiver #1) was seen spitting in the trash can and the resident felt it was inappropriate and the caregiver was also very loud when talking with other staff about personal things." Resident #7 O. Record review for Resident #7 revealed the following: 1. Face Sheet (no date) indicated diagnoses to include [redacted] 2. Nursing Assessment dated 12/05/13, indicated, the resident has [redacted] 3. ISP dated 12/05/13, indicated the resident required total assistance with bathing and dressing. P. Interviews for Resident #7 revealed the following 1. On 02/13/14 at 9:35 am, during interview Family Member #1 for Resident #7 stated, "(Name of Caregiver #1) is loud, and had annoying behaviors and she complained often. She would yell at the residents like they were	A 032		

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kids. I've seen her grab the residents a little harder than what she should and I visit almost every day. Her loud voice bothers other residents while they try to sleep and she makes her own sarcastic remarks about being loud. She was a little more forceful with people which was wrong. She sets her own rules. She doesn't respect others. I brought my concerns to the administration and they were concerned."

2. On 02/13/14 at 8:40 am, during interview, both Administrators stated, that visiting family members mentioned the loudness of (name of Caregiver #1).

Q. On 02/13/14 at 8:40 am, during interview, both Administrators indicated that on 12/23/13, "We were out of town and left our two managers (House Manager #1 and #2) in charge. It would have been my expectation that we would be notified immediately of all incidents and that didn't happen. Our staff know how to report and recognize abuse and/or neglect. When we returned to work on Monday 01/13/14, all of this was brought to our attention by our House Managers that (name of Caregiver #1) was mistreating our residents. The concern we have, is why our staff didn't report any of this when it occurred. (Name of Employee #1) didn't report anything to our House Managers until the night of January 7th. She was responsible for reporting anything immediately. We are not sure why she didn't report anything sooner."

R. Review of the Facility Reporting of Incidents Policy (no date) indicated the following:

1. "The staff member is required to immediately report to the Director of the facility when an incident occurs."

2. Types of reportable incidents are: Abuse...isolation....a threat or menacing conduct

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A 032	Continued From page 12 directed toward a resident that results and might reasonably be expected to result in fear or emotional or mental distress to a resident...Neglect...to provide any service, care that is necessary to maintain the health or safety or resident." S. Review of the facility Resident Rights Policy (no date) indicated, "Each resident will have the right to...humane care, to a safe environment, to be treated with dignity and respect, including the right to be treated in a courteous manner." T. Review of the facility Employee Conduct Policy (no date) indicated, "All staff members will conduct themselves in a professional manner...while working with the residents...Examples of improper behavior include but are not limited to: rough language (i.e. shouting, threatening, swearing, cussing)."	A 032		
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.	A 070		

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A 070	Continued From page 13 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: Refer to 7.1.13.8 INCIDENT MANAGEMENT SYSTEM REPORTING REQUIREMENTS FOR LICENSED HEALTH CARE FACILITIES A. Duty To Report: (1) All licensed health care facilities shall immediately report abuse, neglect or misappropriation of property to the adult protective services division. (2) All licensed health care facilities shall report abuse, neglect, misappropriation of property, and injuries of unknown sources to the division within a twenty-four (24) hour period. (3) All licensed health care facilities shall ensure that the reporter with direct knowledge of an incident has immediate access to the division incident report form to allow the reporter to respond to, report, and document incidents in a timely and accurate manner. Based on observation, record review and interviews, the facility failed to report incidents of resident abuse and neglect to the Licensing authority within a twenty-four (24) hour period which resulted in 6 (R #1, 2, 3, 4, 6, and 7) of 6 cognitively impaired residents who required assistance from staff for all Activities of Daily Living (ADLs) being pulled by the arms when transferring, rough handling, left in the bathroom,	A 070		

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feeling belittled, yelled at, and talked to in a demeaning way. This deficient practice has the potential to affect the health, safety, and welfare of residents in the facility by making them feel afraid. The findings are:

Resident #1
A. Record review for Resident #1 revealed the following:

1. A Department of Health (HFL&C) incident report dated 01/14/14, indicated an incident of abuse involving Caregiver #1 and Resident #1 took place. This incident report indicated that the abuse occurred on 01/02/14 and "Was not brought to the attention of the Administrator until 01/13/14." (This was twelve days after the incident occurred).

2. A written statement dated 01/14/14 from Employee #1 (who was a direct witness) indicated the following: "On 01/02/14 (name of Caregiver #1) went to lift a resident (who was identified as Resident #1) that is a total lift and just pulled [redacted] forward by [redacted] arms to lift [redacted] The resident said "No" as it did hurt [redacted] The resident was clearly upset." The written statement also indicated, "On 01/06/14, she [referring to Caregiver #1] took that same resident (referring to Resident #1) to the bathroom...and the caregiver left [redacted] in the bathroom and didn't go get [redacted] (referring to Resident #1) said (Name of Caregiver #1) said she was 'Just going to leave [redacted] there all night' and (name of Caregiver #1) did nothing to calm [redacted] down and comfort [redacted] she (Caregiver #1) said [redacted] (Resident #1) was 'Just a baby cry.'"

3. Face Sheet (no date) indicated Resident #1 was on Hospice as well as used a wheelchair.

4. Nursing Assessment dated 07/24/13 indicated the resident had [redacted] signs of Dementia, Anxiety, and mobility and ambulation

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issues such as requiring Moderate assistance with using wheelchair. It further indicated the resident has signs of transferring issues from supine (laying on the back) to sitting, and from sitting to standing.

5. Individual Service Plan (ISP) dated 07/28/13 indicated the resident required a one person assist for transfers,has very limited ambulation as well as needing total assistance from staff for bathing, and cannot move wheelchair by herself.

B. Interviews for Resident #1 revealed the following:

1. On 02/13/14 at 8:40 am, during interview both Administrators stated, "With the incident that occurred on 01/02/14 with (name of Resident #1), [redacted] (the resident) would not have been able to tell you what happened due to [redacted] But it would be my expectation that my staff should never pull someone by their arms, what so ever. Pulling them by their arms was a rough transfer. She would not have been able stand or pivot on [redacted] or understand when staff were transferring her. My expectation would have been that we would as the Administrators be notified immediately but that didn't happen. We were not notified [redacted] (resident #1) was in fact a two person assist at times, and (name of Caregiver #1) was [redacted] There was some swelling on [redacted] (Resident #1) arm in relation to the incident with Caregiver #1 on 01/02/14."

2. On 02/13/14 at 10:20 am, during interview, Employee #1 stated, "I witnessed her (referring to Caregiver #1) taking (name of Resident #1) to the bathroom and she just left [redacted] there. The buzzer (referring to the call light) was going off and she (Caregiver #1) was ignoring [redacted] The resident was in tears and [redacted] said (name of Caregiver #1) said she was going to leave [redacted] in there. She is a

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A 070	Continued From page 16 total transfer. I had never seen (name of Resident #1) cry like that. Another time she (referring to Caregiver #1) was getting (name of Resident #1) out of [redacted] wheelchair and she just pulled [redacted] by [redacted] arms. I witnessed this. After this incident with (name of Resident #1) occurred, I thought if she (Caregiver #1) was left alone with a resident, she would probably hurt them." I had enough of her mistreating and mishandling the residents. When I saw for myself that she was capable of hurting someone is when I finally told someone." Resident #2 C. Observation made on 02/13/14 at 12:00 pm, of Resident #2 revealed the resident to be [redacted] D. Record review for Resident #2 revealed the following: 1. A Department of Health (HFL&C) incident report dated 01/14/14 indicated an incident of abuse involving Caregiver #1 and Resident #2 took place. This incident report indicated that the abuse occurred on 12/23/13 and "Was not brought to the attention of the Administrator until 01/13/14." (This was twenty two days after the incident occurred). 2. A written statement dated 01/14/14 from Employee #1 (who was a direct witness) indicated the following: "On 12/24/13, I saw and heard (name of Caregiver #1) talk badly and be little (name of Resident #2) as [redacted] was trying to walk into the kitchen...At the time, (name of Resident #2) had a [redacted] and (name of Caregiver #1) told [redacted] 'No-one wanted [redacted] in there touching things because of the nasty [redacted] had and to go sit down.' I could tell by the	A 070		

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A 070	Continued From page 17 look on (name of Resident #2) face [redacted] feelings had been hurt." 3. Face Sheet (no date) indicated Resident #2 had diagnoses to include[redacted] 4. Nursing Assessment dated 12/04/13 indicated she ambulates (walks independently), sometimes uses a cane, and wanders. It further indicated she has signs of [redacted] 5. ISP dated 12/04/13 indicated the resident requires minimal assistance from staff with Mobility and needs frequent reminders to use cane. E. Interviews for Resident #2 revealed the following: 1. On 02/13/14 at 8:40 am, during interview both Administrators stated, "On December 24th, all I can tell you about this incident is that that was not reported to us until we returned from vacation in January. My expectation would have been that we would be notified immediately with something like this, but that didn't happen. We were not notified. Anyone who talks to any of our residents in that way is just not ok. Regardless is they have [redacted] With (name of Resident #2) she has [redacted] 2. On 02/13/14 at 10:00 am, during interview House Manager #1 stated, "On January 7th, (name of Employee #1) told me that she witnessed (Caregiver #1) grab (name of Resident #2) and tell [redacted] to sit down because of the [redacted] in [redacted] was gross and 'I've told you to sit down.' Prior to this, the House Manager stated that she was not being made aware of this incident that occurred on 12/24/13. 3. On 02/13/14 at 10:20 am, during interview Employee #1 stated, "With (name of Resident	A 070		

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#2), [redacted] and [redacted] was walking into the kitchen and (name of Caregiver #1) told [redacted] 'Get out of the kitchen. It is nasty.' I could tell by the reaction on [redacted] (resident #2) face it hurt [redacted]

4. On 02/13/14 at 10:55 am, during interview, House Manager #2 stated, "I was made aware on January 7th from (name of Employee #1) that resident #2 had a [redacted] (Name of Caregiver #1) was screaming for [redacted] (the resident) to get out of the kitchen."

Resident #3
F. Observation made on 02/13/14 at 11:40 am, of Resident #3 revealed the resident to be laying in bed.

G. Record review for Resident #3 revealed the following:

1. A facility Investigation Report dated 01/16/14 indicated, "On the end of shift on 01/07/14 one resident (identified as Resident #4) was helping (name of Resident #3) down the hall to [redacted] room and (name of Caregiver #1) told (name of Resident #4) 'Not to help [redacted] (Name of Resident #3) became very upset and asked (name of Caregiver #1) not to belittle [redacted] because [redacted] is not a child. (Name of Caregiver #1) told (name of Resident #3) when [redacted] calmed down, [redacted] would help [redacted] and closed the door and left the room."

2. Face Sheet (no date) indicated diagnoses to include [redacted]

3. Nursing Assessment dated 07/05/13, indicated she is able to communicate verbally, has [redacted] It further indicated the resident uses a wheelchair and has mobility issues requiring moderate assistance from staff due to [redacted] [redacted] has transferring issues from

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A 070	Continued From page 19 a [redacted] 4. ISP dated 09/29/13, indicated the resident is unable to ambulate without assistance from staff. H. Interviews for Resident #3 revealed the following: 1. On 02/13/14 at 8:40 am, during interview, both Administrators stated, "With (name of Resident #3) there had been an incident with (Name of Caregiver #1) scolding residents #3 and #4 and we apologized to [redacted] for what happened. She said she was very upset about it and didn't want to work with (Name of Caregiver #1) again. [redacted] is able to verbalize [redacted] needs." 2. On 02/13/14 at 9:45 am, during interview, both Administrators stated, (Name of Resident #3) needs physical assistance with [redacted] wheelchair. [redacted] is a two person transfer and can't bear any weight on [redacted] 3. On 02/13/14 at 10:00 am, House Manager #1 stated, "On the night of January 7th, (name of Employee #1) reported to me that there was an Incident (unknown of the date) involving residents #3 and #4. Resident #4 was helping push Resident #3 in [redacted] wheelchair to [redacted] room and (Name of Caregiver #1) yelled at (name of Resident #3) and said 'Why should you even ask [redacted] to help you anyway. [redacted] is sick to.'" The House Manager then stated, "(name of Resident #3) told (Name of Caregiver #1) 'Please don't be little me, I'm not a child and how upset [redacted] was.' The house manager stated, "In my mind it seemed like she (the caregiver) attempted to isolate (name of Resident #3). I believe she was trying to threaten [redacted] with isolation. The next morning when I came in (name of Resident #3) was very upset and said that (name of Caregiver #1) had be little [redacted] was not nice to [redacted] and this	A 070		

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was not a nice way to even talk to children." The House Manager indicated that this incident had never been reported to her when it occurred as it should have been."

4. On 02/13/14 at 10:55 am, during interview, House Manager #2 stated, "On January 7th, I was made aware of an incident between Resident #3 and #4. (Name of Resident #3) told me, 'I never talked to my kids this way, why should we be talked to like kids.'" The House Manager then stated, "She was upset about the situation and [redacted] was scared of a backlash from (Name of Caregiver #1) but both residents didn't want to say anything to cause trouble."

Resident #4

I. Observation made on 02/13/14 at 11:25 am, of Resident #4 revealed [redacted] to be in a wheelchair and able to make [redacted] needs known.

J. Record review for Resident #4 revealed the following:

1. A facility Investigation Report dated 01/16/14 indicated, "On the end of shift on 01/07/14 one resident (identified as Resident #4) was helping (name of Resident #3) down the hall to [redacted] room and (name of Caregiver #1) told (name of Resident #4) [redacted] (Name of Resident #3) became very upset and asked (name of Caregiver #1) not to belittle [redacted] because [redacted] is not a child. (Name of Caregiver #1) told (name of Resident #3) when [redacted] calmed down.. [redacted] closed the door and left the room."

2. Face Sheet (no date) indicated diagnoses to include [redacted]

3. Nursing Assessment dated 12/05/13 indicated no signs of [redacted] It indicated [redacted] has signs of [redacted] also

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A 070	Continued From page 21 has transferring issues requiring minimal assistance for [redacted] 4. ISP dated 12/05/13 indicated he uses a wheelchair for mobility. K. Interviews for Resident #4 revealed the following: 1. On 02/13/14 at 8:40 am, during interview, both Administrators indicated that they were not made aware of the incident which occurred between Caregiver #1 and Residents #3 and 4. 2. On 02/13/14 at 10:00 am, House Manager #1 stated, "On the night of January 7th, (name of Employee #1) reported to me that there was an Incident (unknown of the date) involving residents #3 and #4. Resident #4 was helping push Resident #3 in her wheelchair to her room and (Name of Caregiver #1) yelled at (name of Resident #3) and said 'Why should you even ask [redacted] to help you anyway. [redacted] is sick to. Don't do it again.'" The House Manager indicated that this incident had never been reported to her when it occurred as it should have been." 3. On 02/13/14 at 10:55 am, during interview, House Manager #2 stated, "On January 7th, I was made aware of an incident between Resident #3 and #4. (Name of Resident #3) told me, 'I never talked to my kids this way, why should we be talked to like kids.'" The House Manager then stated, [redacted] was upset about the situation and [redacted] was scared of a backlash from (Name of Caregiver #1) but both residents didn't want to say anything to cause trouble." 4. On 02/13/14 at 11:25 am, during interview Resident #4 stated, "There was one incident (referring to Caregiver #1). She has a dominate side, she seemed to take over the kitchen. During the interview, regarding Caregiver #1, the resident was observed constrict both arms together and held them crossed in place and	A 070		

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A 070	Continued From page 22 said, "I have nothing else to say about it." Resident #6 L. Observation made on 02/13/14 at 11:50 am, of Resident #6 revealed the resident to be alert, oriented and interviewable. M. Record review for Resident #6 revealed the following: 1. A facility Investigation Report dated 01/16/14 indicated there had been some concerns brought to the Administrators attention regarding Caregiver #1 spitting in the trash and Resident #6 felt it was disrespectful. 2. Face sheet (no date) indicated diagnoses to include [redacted] 3. Nursing Assessment dated 10/07/13, indicated she has signs of [redacted] 4. ISP dated 10/07/13 indicated, [redacted] uses a wheelchair and is a high fall risk. N. Interviews for Resident #6 revealed the following: 1. On 02/13/14 at 11:50 am, during interview Resident #6 stated, "I disliked everything about her (referring to Caregiver #1) and "She was the worst one ever that was working here. She was very rough with patients. To assist, she would grab the residents. Other girls (referring to staff) would say to Caregiver #1 ways to correct her. When putting dishes away, she was coughing in her hand and continued to put the dishes away. I noticed her picking her nose and I was not letting her near me. I avoided her once or twice." I would hate to see her come back and would not even want her to help me me dress. There is an unpleasantness about her."	A 070		

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A 070	Continued From page 23 2. On 02/13/14 at 8:40 am, during interview, both Administrators stated, "One resident (referring to Resident #6) told me she (Caregiver #1) was seen spitting in the trash can and the resident felt it was inappropriate and the caregiver was also very loud when talking with other staff about personal things. Resident #7 O. Record review for Resident #7 revealed the following: 1. Face Sheet (no date) indicated diagnoses to include [redacted] 2. Nursing Assessment dated 12/05/13 indicated, the resident has [redacted] 3. ISP dated 12/05/13 indicated the resident required total assistance with bathing and dressing P. Interviews for Resident #7 revealed the following 1. On 02/13/14 at 9:35 am, during interview Family Member #1 for Resident #7 stated, "(Name of Caregiver #1) is loud, and annoying behaviors and she complained often, and would yell at the residents like they were kids. I've seen her grab the residents a little harder than what she should and I visit almost every day. Her loud voice bothers other residents while they try to sleep and she make her own sarcastic remarks about being loud and is still loud. She was a little more forceful with people which was wrong. She sets her own rules. She doesn't respect others. I brought my concerns to the administration and they were concerned." 2. On 02/13/14 at 8:40 am, during interview, both Administrators stated, visiting family members mentioned the loudness of (name of Caregiver #1).	A 070		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROV DER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASA DE PAZ	4103 LAS CIMBRAS CT SE RIO RANCHO, NM 87124

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG 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 Q. On 02/13/14 at 8:40 am, during interview, both Administrators indicated that on 12/13/13, "We were out of town and left our two managers (House Manager #1 and #2) in charge. It would have been my expectation that we would be notified immediately and that didn't happen. Our staff know how to report and recognize abuse and/or neglect. When we returned to work on Monday 01/13/14, all of this was brought to our attention by our House Managers that (name of Caregiver #1) was mistreating our residents. The concern we have is why our staff didn't report any of this when it occurred. (Name of Employee #1) didn't report anything to our House Managers until the night of January 7th. She was responsible for reporting anything immediately. We are not sure why she didn't report anything sooner. R. Review of the Facility Reporting of Incidents Policy (no date) indicated the following: 1. "The staff member is required to immediately report to the Director of the facility when an incident occurs." 2. Types of reportable incidents are: Abuse...isolation....a threat or menacing conduct directed toward a resident that results and might reasonably be expected to result in fear or emotional or mental distress to a resident...Neglect...to provide any service, care that is necessary to maintain the health or safety or resident." S. Review of the facility Resident Rights Policy (no date) indicated, "Each resident will have the right to...humane care, to a safe environment, to be treated with dignity and respect, including the right to be treated in a courteous manner...	A 070		

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A 070	Continued From page 25 T. Review of the facility Employee Conduct Policy (no date) indicated, "All staff members will conduct themselves in a professional manner...while working with the residents...Examples of improper behavior include but are not limited to: rough language (i.e. shouting, threatening, swearing, cussing)."	A 070		