STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROV DER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	4012	A. BUILDING: _____ B. WING _____	C 05/23/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE SPIRE ASSISTED LIVING OF NORTH ALBUQ AC	7500 OAKLAND AVE NE ALBUQUERQUE, NM 87113

(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 000	Initial Comments The following deficiencies were cited during a Complaint survey completed on 05/23/19 for the state requirements of 7 NMAC 8.2, Regulations for Assisted Living. Complaint Intake NM#35227 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	A 032		

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A 032	Continued From page 1 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. This is a repeat deficiency from survey dated 11/22/2017 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 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	A 032		

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A 032	Continued From page 2 bureau's incident report form and received by the division within twenty-four (24) hours of an incident or allegation of an incident or the next business day if the incident occurs on a weekend or a holiday. The licensed health care facility shall ensure that the reporter with the most direct knowledge of the incident assists with the preparation of the incident report form. Based on record review and interview the facility failed to ensure that incidents of abuse, neglect, exploitation: 1. Were reported to the Licensing Authority within twenty-four (24) hours or the next business day if the incident occurs on a weekend or a holiday. 2. That a follow-up investigation report was submitted to the Licensing Authority within 5 business days from the date the incident occurred. This deficient practice has the potential for all 24 (R #s 1-24) residents identified on the census provided by Assistant House Manager (AHM) on 05/21/19, 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 abuse, neglect, and exploitation, conduct an investigation, and submit a follow-up reports. The findings are: Findings for R #1: A. Record review of the facility's incident report dated 02/12/19, (see incident report) revealed that on 02/01/19, 1. The Administrator Informed R #1 that [redacted] check for services had been returned due to insufficient funds. 2. R #1 informed the Administrator that	A 032		

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A 032	Continued From page 3	A 032		

money was missing from her bank account.

3. The Administrator conducted an internal investigation finding checks written to Direct Care Staff (DCS#s 1 & 2) in violation of the Facility's Code of Conduct.

4. The Facility contacted the Licensing Authority's hotline reporting the 02/01/19 allegation of financial misappropriations/exploitation on 02/12/19.

5. The Facility's investigation follow-up report was faxed to the Licensing Authority on 3/29/19.

B. Record review of Department of Health (DOH) complaint intake NM#35227 revealed that the facility did not:

1. Complete or submit the facility self-report for the 02/01/19 incident alleging financial exploitation of R #1 by DCS #s 1 & 2 to the Licensing Authority until 02/12/19.

2. Submit a 5-day investigation follow-up report to the Licensing Authority until 03/29/19.

C. On 05/22/19 at 9:50 am, during an interview with the House Manager (HM), she confirmed that the incident of financial misappropriation/exploitation of R #1 by DCS #s 1 & 2:

1. Was not reported to the Licensing Authority within 24 hours or the next business day if a weekend or holiday.

2. That an investigation follow-up report was not submitted to the Licensing Authority within 5 business days of the incident occurring.

Findings for R #3:

D. Record review of R #3's facility Incident Report dated 01/02/19 revealed that on 01/02/19 at 7:45 am, R #3 had [redacted] R #3 had a big

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A 032	Continued From page 4	A 032		

[redacted]

E. Record review of facility's incident reports and R #3's resident file revealed there was no documentation that:

1. R #3's witnessed fall with a head injury was reported to the Licensing Authority within 24 hours or the next business day if the incident occurs on a weekend or a holiday.

2. The investigation follow up report had been completed by the facility and/or submitted to the Licensing Authority within 5 business days from the date the incident occurred.

F. On 05/22/19 at 9:50 am, during an interview with the HM, she confirmed that the facility records did not include documentation that:

1. R #3's witnessed fall with a head injury was reported to the Licensing Authority within 24 hours or the next business day if the incident occurs on a weekend or a holiday.

2. The investigation follow-up report had been completed by the facility and/or submitted to the Licensing Authority within 5 business days from the date the incident occurred.

Findings for R #5:

G. Record review of R #5's facility incident report dated 02/10/19 revealed that at 6:30 am, a skin tear on [redacted] of unknown origin was discovered by DCS #5.

H. Record review of R #5's facility incident report dated 04/03/19, revealed that at 2:00 pm, R #5 was found to have 2 bruises of unknown origin on [redacted]

I. Record review of facility's records and R #5's resident file revealed there was no documentation

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A 032	Continued From page 5 that: 1. The incidents recorded on 02/10/19 and 04/03/19 were reported to the Licensing Authority's within 24 hours or the next business day if the incident occurs on a weekend or a holiday. 2. The investigation follow-up report had been completed by the facility and/or submitted to the Licensing Authority within 5 business days from the date the incident occurred. J. On 05/22/19 at 9:50 am, during an interview with the HM, she confirmed that the facility's records did not include documentation that: 1. Incidents recorded on 02/10/19 and 04/03/19 were reported to the Licensing Authority within 24 hours or the next business day if the incident occurs on a weekend or a holiday. 2. Investigation follow up report had been completed by the facility and/or submitted to the Licensing Authority within 5 business days from the date the incident occurred.	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. 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;	A 033		

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A 033	Continued From page 6 (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 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	A 033		

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A 033	Continued From page 7	A 033		

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;
(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

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A 033	Continued From page 8 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) (b) (E) 7.8.2.7 DEFINITIONS: AT. "Misappropriation/exploitation" means the deliberate misplacement of a resident's property, or wrongful, temporary or permanent use of a resident's belongings or money without the resident's consent and is defined in the Incident Reporting Intake, Processing & Training Requirements, 7.1.13 NMAC. 7.1.13.7 DEFINITIONS: J. "Exploitation" means an unjust or improper use of a person's money or property for another person's profit or advantage, financial or	A 033		

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A 033	Continued From page 9 otherwise. Based on observation, interview, and record review, the facility failed to ensure that 1 (R #1) of 1 (R # 1) resident was free from financial abuse and misappropriation by facility staff or management. This deficient practice has the potential for all residents to be at risk of harm from financial abuse, misappropriation, or exploitation. The findings are: A. Record review of R #1's Individual Service Plan (ISP) dated 03/01/18 revealed: 1. R #1 was receiving [redacted] care from the facility. 2. R #1 had [redacted] requiring reminders, queuing, and supervision as needed. 3. The ISP completed and signed by the Facility's Registered Nurse (RN) assessing R #1's cognitive deficits and dementia care. 4. ISP services for [redacted] care were confirmed with RN signature on the ISP on 05/18/18, 09/01/18 & 04/29/19. B. Record review of the facility's incident report dated 02/12/19 revealed that on 02/01/19: 1. The Administrator informed R #1 that [redacted] check for services had been returned due to insufficient funds. 2. R #1 informed the Administrator that money was missing from [redacted] bank account. 3. The Administrator conducted an internal investigation finding checks written to DCS #s 1 & 2 violated the Facility's Code of Conduct by accepting gifts (money) from a resident. 4. DCS #1's employment with the facility was terminated due to exploitation of R #1. 5. R #1 hired a financial fiduciary to assist [redacted] with financial matters.	A 033		

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A 033	Continued From page 10 6. All R #1's bank accounts were secured, and old accounts closed. C. Record review of Department of Health (DOH) complaint intake NM#35227 revealed: 1. On 02/01/19, R #1 reported that [redacted] check books were missing & checks were bouncing. 2. Two checks had been written to & cashed by DCS #1 in the amount of $400.00 each in two separate months. 3. One check was written to DCS #2, but amount was not provided in the intake report. 3. DCS #1 was terminated by the facility for exploitation of R #1. D. Record review of the DCS #1's termination notice dated 02/11/19, & signed on 02/25/19 by DCS #1 revealed that: 1. DCS #1's hire date 12/07/16. 2. DCS #1 signed acknowledging awareness of the facility's Policy-Code of Conduct that states: Staff will not accept gifts of value from a consumer, family member, or stake holder and cannot accept personal favors or benefits that may reasonably be construed as influencing their conduct. 3. DCS #1 was working at the facility on 10/04/18 & 12/05/18 when the following checks were written, endorsed & cashed by DCS #1: a. Check #3319 dated 10/04/18 in the amount of $400.00. b. Check #3022 dated 12/05/18 in the amount of $400.00. 4. Facility found DCS #1 had violated the Facility's Code of Conduct. 5. Facility believed that R #1 had been exploited by DCS #1. 6. The facility will file a complaint of exploitation against DCS #1 to the Licensing Authority.	A 033		

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A 033	Continued From page 11 7. The employment between the facility and DCS #1 was terminated on 02/25/19 due to exploitation of R #1. E. On 05/22/19 at 2:19 pm, during an interview with the facility Administrator (see witness statement dated 05/22/19) she stated: 1. R #1 was informed that [redacted] payment for services and living arrangements was returned due to insufficient funds. 2. R #1 stated that [redacted] went to the bank and money was missing from [redacted] account and that she could not find [redacted] checkbooks. 3. R #1 was asked to go back to the bank for help; R #1 said that [redacted] could not go to the bank by [redacted] 4. R #1 was encouraged to find an advocate to assist [redacted] with [redacted] finances. 5. R #1 stated [redacted] did not give money or write checks to anyone. 6. Administrator introduced R #1 to a case management company, and that R #1 hired the case management company to assist with [redacted] finances. 7. The case management company did an investigation and found that checks were written to both DCS #s 1 & 2. 8. R #1 then stated [redacted] may have written the checks to DCS #s 1 & 2. 9. DCS #1 was contacted and asked to meet with Administrator and Human Resources, but DCS #1 refused. 10. When DCS #1 picked up her check, she was questioned and stated the checks were written as Christmas gifts. 11. DCS #1 was terminated without further discussion. F. On 06/03/19, during an interview with of R #1's Power of Attorney (POA) she stated that:	A 033		

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A 033	Continued From page 12 1. R #1 hired POA on 02/01/19. 2. POA was given authority by R #1 to manage [redacted] finances, to write checks, to review and to pay bills. 3. After conducting a review of R #1's bank accounts, POA found a number of checks written to others that seemed inappropriate. 4. Checks written to DCS #1 from R #1's bank accounts were found, and the POA provided copies of the checks to the facility's Administrator. 5. Checks written to DCS #2 from R #1's bank accounts were found, and the POA provided copies of the checks to the facility's Administrator. G. On 05/22/19, during an interview with the Administrator, she confirmed the findings listed above and that DCS #s 1 &2 allegedly exploited R #1.	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	A 070		

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LIFE SPIRE ASSISTED LIVING OF NORTH ALBUQ AC	7500 OAKLAND AVE NE ALBUQUERQUE, NM 87113

(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 13 Training Requirements 7.1.13 NMAC. [7.8.2.70 NMAC - N, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.70 F B refer to This is a repeat deficiency from survey dated 11/22/2017 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 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	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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A 070	Continued From page 14 bureau's incident report form and received by the division within twenty-four (24) hours of an incident or allegation of an incident or the next business day if the incident occurs on a weekend or a holiday. The licensed health care facility shall ensure that the reporter with the most direct knowledge of the incident assists with the preparation of the incident report form. Based on record review and interview the facility failed to ensure that incidents of abuse, neglect, exploitation: 1. Were reported to the Licensing Authority within twenty-four (24) hours or the next business day if the incident occurs on a weekend or a holiday. 2. That a follow-up investigation report was submitted to the Licensing Authority within 5 business days from the date the incident occurred. This deficient practice has the potential for all 24 (R #s 1-24) residents identified on the census provided by Assistant House Manager (AHM) on 05/21/19, 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 abuse, neglect, and exploitation, conduct an investigation, and submit a follow-up reports. The findings are: Findings for R #1: A. Record review of the facility's incident report dated 02/12/19, (see incident report) revealed that on 02/01/19, 1. The Administrator Informed R #1 that [redacted] check for services had been returned due to insufficient funds. 2. R #1 informed the Administrator that	A 070		

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A 070	Continued From page 15 money was missing from her bank account. 3. The Administrator conducted an internal investigation finding checks written to Direct Care Staff (DCS#s 1 & 2) in violation of the Facility's Code of Conduct. 4. The Facility contacted the Licensing Authority's hotline reporting the 02/01/19 allegation of financial misappropriations/exploitation on 02/12/19. 5. The Facility's investigation follow-up report was faxed to the Licensing Authority on 3/29/19. B. Record review of Department of Health (DOH) complaint intake NM#35227 revealed that the facility did not: 1. Complete or submit the facility self-report for the 02/01/19 incident alleging financial exploitation of R #1 by DCS #s 1 & 2 to the Licensing Authority until 02/12/19. 2. Submit a 5-day investigation follow-up report to the Licensing Authority until 03/29/19. C. On 05/22/19 at 9:50 am, during an interview with the House Manager (HM), she confirmed that the incident of financial misappropriation/exploitation of R #1 by DCS #s 1 & 2: 1. Was not reported to the Licensing Authority within 24 hours or the next business day if a weekend or holiday. 2. That an investigation follow-up report was not submitted to the Licensing Authority within 5 business days of the incident occurring. Findings for R #3: D. Record review of R #3's facility Incident Report dated 01/02/19 revealed that on 01/02/19 at 7:45 am, R #3 had [redacted] R #3 had a big	A 070		

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A 070	Continued From page 16	A 070		

[redacted]

E. Record review of facility's incident reports and R #3's resident file revealed there was no documentation that:

1. R #3's witnessed fall with a head injury was reported to the Licensing Authority within 24 hours or the next business day if the incident occurs on a weekend or a holiday.

2. The investigation follow up report had been completed by the facility and/or submitted to the Licensing Authority within 5 business days from the date the incident occurred.

F. On 05/22/19 at 9:50 am, during an interview with the HM, she confirmed that the facility records did not include documentation that:

1. R #3's witnessed fall with a head injury was reported to the Licensing Authority within 24 hours or the next business day if the incident occurs on a weekend or a holiday.

2. The investigation follow-up report had been completed by the facility and/or submitted to the Licensing Authority within 5 business days from the date the incident occurred.

Findings for R #5:

G. Record review of R #5's facility incident report dated 02/10/19 revealed that at 6:30 am, a skin tear on [redacted] of unknown origin was discovered by DCS #5.

H. Record review of R #5's facility incident report dated 04/03/19, revealed that at 2:00 pm, R #5 was found to have 2 bruises of unknown origin on [redacted]

I. Record review of facility's records and R #5's resident file revealed there was no documentation

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A 070	Continued From page 17 that: 1. The incidents recorded on 02/10/19 and 04/03/19 were reported to the Licensing Authority's within 24 hours or the next business day if the incident occurs on a weekend or a holiday. 2. The investigation follow-up report had been completed by the facility and/or submitted to the Licensing Authority within 5 business days from the date the incident occurred. J. On 05/22/19 at 9:50 am, during an interview with the HM, she confirmed that the facility's records did not include documentation that: 1. Incidents recorded on 02/10/19 and 04/03/19 were reported to the Licensing Authority within 24 hours or the next business day if the incident occurs on a weekend or a holiday. 2. Investigation follow up report had been completed by the facility and/or submitted to the Licensing Authority within 5 business days from the date the incident occurred.	A 070		