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WILLOW WOOD	1008 CHIRICAHUA SE ALBUQUERQUE, NM 87123

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A 000	Initial Comments The following deficiencies were cited during a Complaint survey completed on 01/07/20 for the state requirements of 7 NMAC 8.2, Regulations for Assisted Living Facilities. Complaint Intake NM#41938 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) (2) B (1) (2) This is a repeated deficiency from Survey dated 08/15/19 Based on record review, observation and interview, the facility failed to ensure for 2 (R #s 5 & 6) of 2 (R #s 5 & 6) residents whose resident files were reviewed for compliance that the facility: 1. Reported incidents of abuse, neglect unusual occupancies to the Licensing Authority within 24 hours or the next business day if a holiday or weekend. 2. Conducted an internal investigation and submitted an investigation follow-up report to the Licensing Authority within (5) five business days of the date the incident occurred. This deficient practice has the potential for all residents to be at risk of being abused, neglected, and/or injured if the facility is not: 1. Reporting incidents of verbal abuse and unusual occupancies to the Licensing Authority within 24 hours or the next business day if a holiday or weekend. 2. Conducting internal investigations and submitting investigation follow-up reports to the Licensing Authority within (5) five business days of the date the incident occurred, resulting in no oversight by the Licensing Authority.	A 032		

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A 032	Continued From page 2 The findings are: Findings for R #5 A. On 12/20/19 at 10:07 am, during observation of R #5, [redacted] was observed being transferred by Direct Care Staff (DCS #2) from [redacted] wheelchair to a recliner. DCS was observed having difficulty transferring the resident and R #5 was observed to have [redacted] B. On 12/20/19 at 10:13 am, during an interview with DCS #2, she stated that approximately 4 days ago R #5 [redacted] was in the hospital for 2 days and returned with [redacted] C. Record review of the facility's internal Incident Report dated 12/14/19 revealed, no documentation that R #5's [redacted] in [redacted] room at 5:01 am, requiring hospitalization and [redacted] was reported to the Licensing Authority. D. On 12/20/19 at 11:02 am, during an interview with the Administrator, he confirmed that the 12/14/19 incident for R #5 was not reported to the Licensing Authority. Findings for R #6 E. Record review of the Department of Health (DOH) Complaint Intake #41938 revealed an allegation that R #6 was verbally abused by DCS #3.. The complaint included an audio tape of the incident that occurred on (date unknown) or around 12/02/2019. F. Record review of R #6's resident chart revealed no documentation of the incident of DCS #3 being verbally abusive to R #6. There was no internal incident report, internal investigation	A 032		

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notes, or documentation that:

1. That the incident was reported to the Licensing Authority within 24 hours or the next business day if a holiday or weekend.

2. An internal investigation was conducted and/or that an investigation follow-up report was submitted to the Licensing Authority within 5 business days of the date the incident occurred.

G. On 12/20/19 at 10:49 am, during an interview with the Administrator, he stated that the facility did conduct an internal investigation of the incident where DCS #3 could be heard being verbally abusive to R #6 on the Audio recording and confirmed that the facility did not submit an investigation report, or follow-up report within 5 business days to the Licensing Authority that included 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.

3. Plans for further actions in response to the incident.

H. On 12/20/19 at 11:00 am, during an interview with the Administrator he confirmed that:

1. He was aware of the incident and had listened to the audio recording prior to the 12/20/19 complaint investigation.

2. It was DCS #3 who could be heard being verbally abusive and aggressive to R#6 and using a threatening tone and profanity directed at R #6 to make the [redacted] succumb to grooming and dressing against [redacted] will, and ignoring the resident plea to "STOP".

3. R #6's had a health crisis/heart attack while living at the facility on 12/13/2019, resulting in the resident being transported to the hospital

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A 032	Continued From page 4 and passing away. I. Record review of the written witness statement from the Administrator dated 12/23/19. he wrote "Once I became aware of the incident, I did not think to report it to the Licensing Authority.	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; (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:	A 033		

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A 033	Continued From page 5 (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 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;	A 033		

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A 033	Continued From page 6 (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 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	A 033		

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A 033	Continued From page 7 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 (1) (5) (11) (a) Based on record review and interview the facility failed to ensure that residents: 1. Rights were protected and that residents were treated with courtesy, respect, dignity, and compassion. 2. Received humane care. 3. Were free from verbal, physical, and emotional abuse and neglect. This deficient practice has the potential for all 5 (R #s 1-5) residents identified on the census provided by Administrator on 12/20/2019 to be at risk of harm, injury, and/or death if: 1. Resident rights are not protected and the the Direct Care Staff (DCS) do not treat them with courtesy, respect, dignity, compassion, and in a humane manner. 2. Residents are verbally, physically and emotionally abused and neglected by the DCS. The findings are: A. On 12/20/19 at 11:02 am, during an interview with the Administrator, when asked about the complaint regarding DCS #3 being verbally abusive to R #6 while giving [redacted] a shower, he stated he was aware of the audio recording and confirmed that it was DCS #3 who could be heard being verbally abusive to the resident. He stated	A 033		

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that when he learned about the incident he did write DCS #3 up and required her to retake trainings on how to talk to residents. DCS #3 was removed from the shower scheduled for R #6 and he added additional DCS to daytime schedule. The Administrator stated that he was unaware of any other incidents where DCS #3 or any DCS being abusive to residents.

B. On 12/23/19 at 10:08 am, during an interview with DCS #3 when asked if she was aware of any incident that may have occurred within the last 60 days where a resident may have been yelled at or spoken to in an inappropriate way, DCS #3 stated that she does not know if any incident within the last 60 days where she or any other caregiver yelled at a resident. She stated that when she gets frustrated that she walks away from the resident and tries again later. DCS #3 stated that R #6 (now deceased) was sometimes difficult, hard to shower. and that she would sometimes get frustrated with [redacted] DCS #3 said that she might have raised [redacted] voice at R #6 once, but then she was counseled on it. On the day (exact date unknown) of the incident that DCS #3 referenced regarding DCS #6, she stated that R #6 kept pulling [redacted] arm out of [redacted] clothing and that she asked [redacted] to please to put [redacted] clothes on. DCS #3 said that she loves her residents and has never been mean to them. DCS #3 stated that she has never been abusive to any resident and that when she gets frustrated she would walk away. DCS #3 admitted that she was stressing out about R #6 and stated that she felt bad about that incident she referenced and that that was the only incident she knew of. DCS #3 reiterated that she doesn't want to be mean to the residents.

C. On 12/23/19 at 2:25 pm, during an interview, anonymous #1 reported that numerous calls from

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the facility DCS were received with concerns regarding DCS #3 being verbally abusive toward the residents in the home. Anonymous #1 had listened to the audio tape of the incident where DCS #3 could be heard yelling and being verbally abusive towards R #6, that this incident was not the first time [redacted] behaved this way, and had been spoken to before regarding [redacted]

D. On 12/23/19 at 3:48 pm, during an interview, Anonymous #2 reported that DCS #3 has talked rudely and been mean to residents many times, not just this one incident.

E. On 01/03/20 at 8:15 am, during review of the 6:48 minute audio recording of an interaction between DCS #3 and R #6 revealed:

(1) DCS #3 verbally abusing R #6 by cussing, raising her voice, speaking aggressively and verbally berating the resident.

(2) Transcription of the 6:48 minute audio recording of DCS #3 and R#6 recorded by [name of] a coworker and included in the complaint intake report revealed:

a. DCS #3 and R #6 speaking loudly and yelling in back ground

b. R #6 making moaning sounds and yelling "aughhhh"

c. DCS #3 (.15 sec) you are getting me stressed out man, you are too much, put it on ...stop ...

d. R #6 loud screaming from resident, undiscernible sounds from resident

e. DCS #3 yelling for R #6 to stop, por favor, stop, put your arm in, put it in, put your arm in, put it in. How many times am I going to tell you to put your damn shirt on ...put it on, this is ridiculous, put on the shirt.

f. Sounds ...Static sound, blocking DCS #3 and R #6 speaking (@ .35 sec)

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g. R #6 (@.40 sec) Resident making sound "ough ough ...
h. DCS #3 You got a problem.
i. R #6 (@.47 sec) aughhhh
j. (@50 sec) Static sound people speaking ...Yelling in back ground
k. DCS #3 (@.58 sec) Put your arm in. Por favor.
l. R #6 making whimpering sound.
m. DCS #3 Put it in, put it in, put your arm in [name] of R #6, put your arm in put it in, why do you make it harder. (@1:03) put your arm in.
n. R #6 aughhh
o. DCS #3 Put it. Put your arm in [name] of R #6. Put your arm in, put your arm in. put it in, put your arm in. Put it in. Put your arm in.
p. R #6 Undiscernible sounds from resident, escalated moaning/yelling, aaah,
q. DCS #3 Why is it so hard to put a shirt on, put it in, put it in. It's not that hard. Put it on. Put your shirt on.
r. R #6 (@1.32) yelling dududu, aughhhh
s. DCS #3 It's not hard.
t. R #6 aughhhh, yelling
u. DCS #3 Why do you make it so hard
v. R #6 aughhhh, yelling
w. DCS #3 Why do you make it so hard, por aqui. por aqui . Put it in. Put it in your shirt. Put it on. Put it on. Put it in por favor. Why do you do this? Why? Put your arm in, why do you make it so damn hard to put your damn shirt on. I'm gonna put it on anyway.
x. R #6 (@ 2.05) Yells out ....Noooo.
y. DCS #3 I'm gonna put it on anyway. [name] of R #6 just put it on.
z. R #6 "Let me, Let me", undiscernible. Let meeee..
aa. DCS #3 Go put your pants on now. Put your pants on. Why do you make it so hard

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man ...

bb. Sounds, coughing that blocked DCS#3 and R#3 sounds(@ 2:30)

cc. R #6 Yelling in background. Undiscernible.

dd. DCS #3 No, put your arm in. Your making this hard when it is not. Por aqui.

ee. R #6 mumbling

ff. DCS #3 No. What gives. Your making this hard [name] of R #6, it's not. It's not that hard. It's not .... Undiscernible.

gg. R #6 Mumbling ...

hh. DCS #3 No just put your arm in. [name] of R #6...its not that hard its not. (@ 2:58) ...? I'll never know you do this every day and you are use to getting dressed, use to getting dressed [name] of R #6..It's nothing new you do it every day. Every day.

ii. R #6 HELP (@3:21)

jj. DCS #3 Every day.

ll. R #6 HELP

mm. DCS #3 (@3:23) Every day. Fuck No, no one's stopping, no one's stopping.

nn. Quiet for 2 seconds.

oo. DCS #3 It's not that hard, It's not that hard. You make it hard. You make it hard for yourself.

pp. R #6 Leave me alone (@3:40). Spanish words ...do me amada?. [redacted] ...STOP.

qq. DCS #3 It's hair spray, it's called hair spray [name] of R #6. Hairspray.

rr. R #6 Help. Yelling. Noooo. Cut it out. Cut it out.

ss. DCS #3 STOP. STOP .

tt. R #6 Yelling out.

uu. DCS #3 You're making it hard for your self all the time, all the time, no reason. No reason at all. You'd be done right now it you didn't fight me putting on your shirt. Please don't ruin

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your shirt, please. Por que, por favor. Por favor stop.

vv. R #6 Res making sounds, trying to speak. Undiscernible words.

ww. DCS #3 Go get some aguas. Let me brush your teeth ...open.

xx. DCS #3 Yelling out. Aughhhhh yelling. Higher pitched gagging sound.

yy. DCS #3 That's mouthwash so your mouth isn't so stinky. So, your breath wont stink. Pick this up. Pick your pants up. Your pants.

zz. R #6 mumbling.

aaa. DCS #3 Your briefs

bbb. DCS #3 You are too much man, too much. You make this difficult for no reason, no reason at all [redacted]

ccc. R #6 Undiscernible words. Aughhh.

ddd. DCS #3 No, no, no,

eee. R #6 moaning. undiscernible words. (Louder) NO. mumbling. NO.

fff. DCS #3 Leave it [redacted] for what for what, why are you a [redacted]

ggg. R #6 Mumbling. Trying to speak.

hhh. DCS #3 No you do this every day, you should be use to it already, you do this every day. You should be use to it every day.

iii. R #6 mumbling. Trying to speak.

jjj. DCS #3 No don't touch me, don't touch me. Your hands are ...playing with your ass all day, all day you touch your butt and everything else. Why do you make this hard I don't understand. Undiscernible.

kkk. R #6 ...mumbling.

lll. DCS #3 No No No it's not that hard I don't know why you do that [name] of R #6. Por que. You make it hard on yourself. -End

F. On 01/07/20 at 8:12 am during observation of a video recording dated 12/02/19 from 8:00 am

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROV DER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2292	A. BUILDING: _____ B. WING _____	C 01/07/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOW WOOD	1008 CHIRICAHUA SE ALBUQUERQUE, NM 87123

(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
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thru 8:00 pm, provided by the Administrator revealed the following interactions between DCS #3 and R #1, R #4 and R #6 in the living room. Transcription of the video is as follows:

1. Living room camera footage starting at:

a. 10:37:30 am - DCS #3 has R #4 down on the couch and then walks down hallway by front door.

b. 10:37:52 am - R #4 stands back up.

c. 10:37:57 am - 2nd caregiver comes over to assist R #4. R #4 and caregiver start walking toward the door.

d. 10:38:07 am - DCS #3 returns from hallway.

e. 10:38:12 am - DCS #3 tries to take R #4 from the 2nd caregiver.

f. 10:38:25 am - R #4 grabs 2nd caregiver trying to pull away from DCS #3.

g. 10:38:45 am - DCS #3 gets wheelchair and wheels it over to R #4 and 2nd caregiver.

h. 10:38:58 am - 2nd caregiver helps R #4 into wheelchair.

i. 10:39:22 am - DCS #3 disappears off camera with R #4 down hallway by front door.

j. 10:39:35 am - 2nd caregiver leaves

k. 10:44:51 am - DCS #3 returns on camera with R #4 in wheelchair

l. 10:45:12 am - DCS #3 assists R #4 back onto the couch. (pulls on sweater to get R #4 to sit).

m. 10:45:22 am - DCS #3 starts to lean in towards R #4 to speak.

n. 10:45:26 am - DCS #3 turns back around towards R #4 with an aggressive stance and gestures.

o. 10:45:35 am - DCS #3 starts to walk away and turns back around and leans back towards R #4 acting aggressively.

p. 10:45:45 am - DCS #3 walks away.

q. 10:45:52 am - DCS #3 comes back

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	2292	A. BUILDING: _____ B. WING _____	C 01/07/2020

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towards R #4 acting aggressively

r. 10:46:09 am - DCS #3 leans in and gets into R #4s face.

s. 10:46:20 am - DCS #3 walks over to the half door and turns to face R #4 .

t. 10:46:33 am - DCS #3 walks back towards R #4, appears to be escalated and acting aggressively.

u. 10:46:44 am - DCS #3 starts to walk away towards the half door at the kitchen.

v. 10:46:49 am - DCS #3 enters the kitchen through the half door.

w. 10:46:56 am - DCS #3 comes out of the kitchen though half door and walks back into the kitchen through the open threshold.

x. 10:47:20 am - DCS #3 comes out of kitchen through open threshold

y. 10:47:29 am - DCS #3 walks over to R #1 and acts like she is whispering while looking at R #4.

z. 10:47:45 am - Walks toward R #6 and acts like she is whispering and looking at R #4.

aa. 10:47:58 am - DCS #3 makes aggressive gesture towards R #4 as she walks down the hall by the front door and disappears off screen.

bb. 10:48:57 am - DCS #3 returns on camera from hallway and walks to the kitchen half door.

cc. 10:49:28 am - DCS #3 walks back out of the kitchen and starts towards R #4 in an aggressive manner.

dd, 10:49:48 am - DCS #3 grabs sweater off couch and walks over to R #6.

ee, 10:49:50 am - DCS #3 goes down hallway by kitchen dragging sweater until she disappears off camera

ff. 10:50:17 am - DCS #3 returns on camera, walks into kitchen through half door and walks out of kitchen. Aggressively addresses R

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A 033	Continued From page 15	A 033		

#4.

gg. 10:50:29 am - DCS #3 returns to the kitchen.

hh. 10:50:45 am - DCS #3 comes out of kitchen approaches R #4 in an aggressive manner.

ii. 10:51:00 am - DCS #3 returns to the kitchen.

jj. 10:51:15 am - DCS #3 walks out of the kitchen towards R #6 and R #1 pointing and talking.

kk. 10:51:33 am - DCS #3 disappears down the hallway by the front door.

ll. 10:53:28 am - 10:57:36 am - R #4 sitting on couch and pointing at hallway where DCS #3 went multiple times.

mm. 10:57:39 am - DCS #3 walks back into room from hallway.

nn. 10:57:41 am - DCS #3 appears to be yelling at R #4.

oo. 10:57:52 am - DCS #3 walks aggressively towards R # 4.

pp. 10:57:55 am - DCS #3 leans in on R #4 and is pointing at the resident, acting aggressively, and in the residents face.

qq. 10:58:07 am - DCS #3 starts to walk away but turns back around

rr. 10:58:17 am - DCS #3 walks back towards R #4 acting aggressively.

ss. 10:58:25 am - DCS #3 walks away from R #4.

tt. 10:58:30 am - DCS #3 turns around.

uu. 10:58:34 am - DCS #3 walks off camera down hallway by front door.

vv. 11:07:06 am - DCS #3 peers around corner and disappears back down hallway

ww. 11:19:30 am - DCS #3 returns when R #6's husband enters. DCS #3's behaviors stops when R #6's husband arrives.

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A 033	Continued From page 16 G. On 01/07/20 at 1:17 pm, during an interview (phone) with the Administrator he confirmed the video recording and video transcription of DCS #3's inappropriate and aggressive behaviors and interactions with R #s 1, 4, 6 , until R #6's husband entered the facility.	A 033		