Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	7097	A. BUILDING: _____ B. WING _____	C 02/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE VILLAGE AT ALAMEDA	8810 HORIZON BLVD NE ALBUQUERQUE, NM 87113

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 000	Initial Comments The following deficiencies were cited during a Complaint survey completed on [redacted]24 for the state requirements of NMAC 7.8.2, Regulations for Assisted Living for Adults. Census: 66 Complaint Intake [redacted] was investigated 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	A 032		

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A 032	Continued From page 1 NMAC; and (3) plans for further actions in response to the 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) 7.1.13 INCIDENT REPORTING, INTAKE, PROCESSING AND TRAINING REQUIREMENTS Refer to 7.1.13.7 W. and 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 bureau's incident report form and received by the	A 032	Reporting of Incidents The violation of Reporting of Incidents has been corrected by the Executive Director. The Executive Director has received training on the Reporting process, along with the Director of Health Services, from the D.O.H. The Executive Director has been given the correct forms, steps, and navigation on the Reporting of incidents process, including the timeframe to report-within 24 hours or by next business day, if it falls on a weekend or holiday. The Executive Director, along with the DHS, had scheduled trainings with the medication supervisors regarding the reporting process, filing incident reports, and "who, when, and how" to file the proper reports. These trainings included abuse, neglect, exploitation, and injuries. Posters from the DOH on reporting are placed in three locations in the community, where they can be easily accessed. Reporting of incidents will be followed through and monitored by the Executive Director. Once an incident is reported, Executive Director will be notified of the incident and will be aware of the timeframe to report (within 24 hours or by next business day, if it falls on a weekend or holiday), and, will review & confirm that the reporting is completed in a timely manner. This procedure will ensure the community will stay in compliance with the Reporting of Incidents. The corrective action has been put into place effective immediately and there will be trainings to continue to ensure ongoing compliance. [redacted]/24	

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A 032	Continued From page 2 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 for 3 (R #s 1, 2, and 3) of 3 (R #s 1-3) residents whose Incident Reports were reviewed for compliance, that the facility reported any incident or unusual occurrence, including unexpected death, and exploitation to the Licensing Authority within twenty-four (24) hours or by the next business day, if it is a weekend or a holiday. This deficient practice could likely result in the residents to be at risk of harm and/or financial loss if incidents occur and there is no oversight by the Licensing Authority. The findings are: The findings related to the exploitation are: Findings for R #1 A. Record review of intake [redacted], received on [redacted]/22 by the Licensing Authority, revealed [Name of bank employee] reported on [redacted]/22, R #1 called the bank due to [redacted] checks being lost. [Name of bank employee] went over the checks in R #1's account and confirmed Name of Direct Care Staff (DCS) #3, a previous caregiver at the facility, had a check cleared in R #1's account which was confirmed by the [Name of bank employee] after reviewing the checks. B. Record review of a Police Report [redacted], dated [redacted]23, revealed that on [redacted]/22, R #1	A 032		

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A 032	Continued From page 3 reported that on [redacted] found that [redacted] checkbook was missing and at the time, no checks had been written and [redacted] did not know if it was taken or misplaced [redacted] was later notified that a check was cashed in the amount of 550.00 dollars by DCS #3 who was a previous staff member at the facility. C. On [redacted]/24, at 12:45 pm, during an interview, the Director confirmed there had been incidents of exploitation that occurred and affected R #'s 1, 2, and 3; The employee that had exploited the residents was DCS #3. DCS #3 was hired by the facility as a caregiver and was only with the facility for a few months (could not remember dates of employment) and was fired due to the facility receiving a disqualifying conviction on [redacted] employee clearance Caregiver Criminal History Screening (CCHSP). On an unknown date, R #1 received a call from the bank notifying R #1 that someone had accessed [redacted] bank account. The Director assisted R #1 on the phone while talking with the resident's bank; the bank confirmed with the Director and R #1 that a check had been cashed from the resident's account and made out to Name of DCS #3. They (facility) did not report the exploitation incident to the Licensing Authority because DCS #3 had been terminated. Findings for R #2 D. Record review of Police Report [redacted] dated [redacted]/22 revealed R #2 had reported that [redacted] bank checkbook and a credit/debit card was stolen. E. Record review of Police Report [redacted] dated [redacted]/23, revealed that R #2 stated that on [redacted]/22, [redacted] found that [redacted] credit/bank card was taken. R #2 called [redacted] bank and put a hold on	A 032		

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A 032	Continued From page 4 [redacted] account [redacted] reported the issue, at that time there was not any money stolen. On [redacted]/22, three charges processed on her account thorough [Name of money transfer company], in the amounts of $0.04, $0.12, and $0.16. On [redacted]/22, a charge in the amount of $732.32 from [Name of Insurance Company]. F. On [redacted]/24, at 12:45 pm, during an interview, the Director confirmed they (facility) did not report the exploitation incident for R #2 to the Licensing Authority because DCS #3 had been terminated. G. On [redacted]24 at 1:06 pm, during an interview, the Business Office Manager (BOM) stated R #2's family came to [redacted] (BOM) and said the R #2's bank notified [redacted] of suspicious activity on [redacted] bank account. They (bank) had placed a hold on the account for multiple charges that were made to [redacted] bank card. R #2's bank confirmed with R #2 that [redacted] card was used to make a purchase at [Name of store] for an order that was addressed to Name of DCS #3. Findings for R #3 H. Record review of Police Report [redacted] dated [redacted]22, revealed the Director of the facility reported that R #3 was one of the victims who had [redacted] checkbooks stolen by DCS #3. R #3's daughter later spoke with [redacted] (R #3's) bank who advised [redacted] a male had come into the bank and attempted to cash a check for $500 written out to [name of DCS #3] from R #3's bank account. The bank refused to cash in the check due to suspicious activity. A few moments later an unknown woman cashed a check for $300 from R #3's account. [Name of Officer] spoke to R #3's daughter who stated the bank provided [redacted] (R #3's daughter) with photos of the check and	A 032		

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A 032	Continued From page 5 identification of the suspects. [Name of Officer] called R #3's bank and was told they (bank) would provide the officer with pictures and information of the suspects. The resident had $60 in money/cash/currency stolen. I. Record review of an email dated [redacted]/22, from [Name of Bank Teller] revealed the bank had a non-member wanting to cash a check from R #3's account. The signature did not match, so they (bank teller) reached out to the joint owner [Name of R #3's Daughter] and [redacted]found R #3's checkbook and noticed the majority of checks were missing. There was a check written to [Name of DCS #3] for $550 and had the memo, "Christmas" on the check. J. On [redacted]/24 at 12:45 pm, during an interview, the Director confirmed: 1. The resident's family came in from out of state after R #3 passed away and notified the facility of a problem with the resident's bank account. 2. They (R #3's family) were told by R #3's bank that DCS #3 had gone into the resident's bank with one of the resident's checks and attempted to cash it. 3. DCS #3 was accompanied by one of his female friends (non-facility staff), who also cashed a check from the resident's account. 4. They (facility) did not report the exploitation incident for R #3 to the Licensing Authority because DCS #3 had been terminated. The findings related to R #3's death are: K. Record review of a text message screenshot provided by R #3's daughter on [redacted]/24, at 2:59 pm, revealed she sent a text message to Officer #1 with the [name of local police department]	A 032		

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A 032	Continued From page 6 revealed: 1. R #3 was found nonresponsive by the staff at the facility and was transported to the hospital on [redacted] 2. R #3 was administered [redacted] on [redacted] because [redacted] had taken [redacted] was being treated with a substitute drug for [redacted] and [redacted] in place of [redacted] and was now receiving end-of-life care at the hospital. L. On [redacted]/24, at 8:40 am, during an interview, R #3's daughter confirmed: 1. The staff at the facility on [redacted]/22 called and informed her that R #3 couldn't be awakened. 2. R #3 was taken to the hospital and later tested positive for methadone. Her (R #3's daughter) reported that R #3 had no history of drug use and had not been prescribed methadone. 3. Emergency Medical Technicians (EMTs) reported that R #3 was found unresponsive near an empty bottle of [redacted] 4. R #3 died on [redacted] at the hospital from [redacted] M. On [redacted]24 at 9:02 am, during an interview, the Director confirmed: 1. R #3 was found unresponsive by staff at	A 032		

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A 032	Continued From page 7 the facility and was transported to the hospital on [redacted]22. 2. There was not an internal incident report regarding the incident with R #3 being unresponsive on [redacted]22. 4. The incident was not reported to the Licensing Authority.	A 032	Resident Rights	
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.	A 033	The violation of Resident Rights resulting in residents suffering financial hardship has been corrected by the Executive Director. The E.D. has provided Directors with the resident's rights to ensure they are understood and the importance of keeping in compliance to protect our residents. All directors have understood and agree to uphold these resident rights. The Executive Director has reviewed the resident files and found that all residents have signed the resident rights form upon arriving at the community. We have a Resident Council meeting scheduled for [redacted] at which time I will discuss the resident rights forms they have signed. The E.D., has reviewed the fingerprint policy with the Business Office Manager and discussed the importance of having clearance results before any new employee works independently. This has been addressed with all hiring Directors In the community. The E.D. has confirmed that the resident rights are posted in the community where all residents have easy access, as well as the ombudsman contact information.	

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A 033	Continued From page 8 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 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	A 033	The E.D. has sent a letter to all residents reminding them, as stated in our lease agreement, that we "urge them not to retain valuable items or large amounts of cash in their apartment." We have also encouraged them to use the locked drawers, available in all apartments, for items of high value and any financial documents (including checks & credit cards). We have also sent an email to all families reminding them of the importance of protecting the resident's valuables. The E.D. will be notified of all new hires and confirm receipt of all background/fingerprint clearance letters. These corrective actions are taken effect immediately and will be reviewed to ensure compliance. [redacted]	

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A 033	Continued From page 9 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 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	A 033		

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A 033	Continued From page 10 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) Based on record review and interview, the facility failed to ensure for 3 (R #s 1, 2, and 3) of 3 (R #s 1-3) residents were free from financial abuse and misappropriation/exploitation of funds by Direct Care Staff (DCS). This deficient practice resulted in residents suffering financial hardship/loss, because the facility did not ensure resident's personal property/possessions were protected from misappropriation by DCS. The findings are: A. Record review of DCS #3's Employment Status file revealed a hire date of [redacted]/22 and a termination date of [redacted]22. R #1 B. Record review of intake [redacted] received on [redacted]22, by the Licensing Authority revealed, [Name of bank employee] reported on [redacted]22. R #1 called the bank due to [redacted] checks being lost; [Name of bank employee] went over the checks in R #1's account and confirmed a check was made out to [Name of DCS #3]. C. Record review of a Police Report [redacted] dated [redacted]23, for R #1 revealed R	A 033		

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A 033	Continued From page 11 #1 reported: 1. On [redacted]22, in the morning, R #1 noticed that [redacted] checkbook was missing and advised the staff at the facility (staff not named). 2. At the time there were no checks written and [redacted] did not know if they were taken or misplaced. 3. R #1 was later notified that a check was cashed in the amount of 550.00 dollars to Name of DCS #3 who was a previous staff member at the facility. 4. DCS #3 was let go before [redacted] was told [redacted] (DCS #3) had written out a check from [redacted] account. 5. R #1 did not give DCS #3 [redacted] checkbook, or give permission for [redacted] checks and forge [redacted] signature. 6. The following items that were stolen from R #1 on [redacted]/22, and was documented on the police report are: a. Checkbook b. Check numbers including 740-760 c. Forged and counterfeited checks. d. $550.00 from a forged check. D. On [redacted]/24, at 9:59 am, during an interview, R #1's son confirmed when R #1 was living at the facility, he was told by facility staff (staff not named) that an employee had stolen $500.00 from R #1's account, exact date not recalled. E. On [redacted]24, at 9:15 am, during an interview, the Director of Compliance with [Name of local Credit Union], confirmed there was an incident report completed for the incident of exploitation and confirmed one check from R #1's account was used and cashed (exact date of check not recalled). The check was payable to [Name of DCS #3] and was cleared from the Credit Union on [redacted]/22.	A 033		

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THE VILLAGE AT ALAMEDA	8810 HORIZON BLVD NE ALBUQUERQUE, NM 87113

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 033	Continued From page 12 F. On [redacted]24 at 12:45 pm, during an interview, the Director confirmed: 1. There was an incident of exploitation that occurred and affected R #'s 1,2 and 3; The employee who exploited the residents was DCS #3. 2. DCS #3 was hired by the facility as a caregiver and was only with the facility for a few months (could not remember dates of employment) and was fired due to the facility receiving a disqualifying conviction on[redacted] employee clearance through the Caregiver Criminal History Screening Program (CCHSP). 3. On an unknown date, the facility received a call from R #1's bank and was told that someone had accessed R #1's bank account. 4. The Director assisted R #1 on the phone while talking with the resident's credit union; credit union confirmed with the Director and R #1 that a check in the amount of $500.00 had been cashed from the resident's account and made out to [Name of DCS #3]. R #2 G. Record review of a Police Report [redacted]/2,3 for R #2 revealed R #2 reported: 1. On [redacted]/22, R #2 noticed [redacted] credit/bank card had been taken. 2. [redacted] called [redacted] bank and put a hold on [redacted] account, and reported the issue. No money was stolen at that time. 3. On [redacted]/22, three charges processed on R #2's account through [Name of money transfer company] in the amounts of $0.04, $0.12, and $0.16. 4. On [redacted]22, a charged in the amount of $732.00 from R #2's account from an unknown	A 033		

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A 033	Continued From page 13 purchase (possible insurance premium). 5. The following items that were stolen from R #2 on [redacted]22 and was documented on the police report are: a. Credit/Debit card b. Money/cash/currency through [Name of money transfer company] in the amount of $732.32 from an unknown purchase. H. On [redacted]/24, at 1:06 pm, during an interview, the Business Office Manager (BOM) confirmed: 1. A police report was completed at the facility for R #1 and R #2. R #3's family completed a police report on their own. 2. R #2's family came to [redacted] and said the resident's bank notified R #2 that there was suspicious activity on [redacted] bank account. They (bank) had placed a hold on the account for multiple charges that were made to [redacted] bank card. R #2's bank confirmed with R #2 that [redacted] card was used to make a purchase (unknown amount) at [Name of store] for an order that was addressed to [Name of DCS #3]. 3. DCS #3 was fired on [redacted]22 for a disqualifying conviction that was received on his CCHSP, which was before the issues of fraud and exploitation were brought to their attention regarding R #s 1, 2, and 3. 4. The checks that were cashed from R #1 and R #3 account were written out to [Name of DCS #3] and [Name of [redacted] female friend (non-facility staff)]. I. On [redacted]24, at 10:06 am, during an interview, R #2's son confirmed he was told by the facility (staff not named) that one of the employees got into R #2's wallet and stole [redacted] credit/bank card. The facility contacted the police and filed a police report and R #2's credit union credited the funds back to [redacted] account.	A 033		

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A 033	Continued From page 14 R #3 J. Record review of an email conversation created by [Name of the Senior Teller at Local Credit Union], dated [redacted]22 revealed: 1. The credit union had a non-member wanting to cash a check from R #3's account. 2. The signature did not match so they tried to reach out to the member, and R #3's daughter (joint member) answered and informed the credit union that R #3 was in the hospital was nonverbal at the moment. 3. R #3's daughter told them that she found R #3's checkbook and noticed that the majority of the checks were missing and asked for them not to cash that check and to be on the lookout for any other checks that might be presented. 4. The check was written to [Name of DCS #3] for $550.00 and in the memo was written "Christmas". Two photo identifications (ID's) belonging to DCS #3 and another unknown female were attached to the email thread. K. On [redacted]24 at 1:32 pm, during an interview, R #3's daughter confirmed: 1. After R #3 passed away, [redacted] found a diary in R #3's room. R #3 had written in [redacted]diary that [redacted](R #3) had been robbed twice. 2. Daughter was a joint account holder on the resident's (bank account) and received a call that DCS #3 and a female friend were trying to cash a check under the resident's account. 3. The bank denied the check that was written out to [Name of DCS #3] in the amount of $500.00, but did process the check that was written out to [Name of DCS #3's female friend] in the amount of $300.00. 4. Daughter went to the bank and had R #3's account numbers changed. The bank provided	A 033		

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A 033	Continued From page 15 [redacted]aughter) with the documentation of DCS #3's Driver's License (DL) that [redacted]rovided when attempting to cash the check; Bank also provided the DL for DCS #3's female friend who also cashed a check in the amount of 300.00 dollars. 5. Police called [redacted]from the facility and took a report over the phone about the exploitation. [redacted]could not recall the exact date. L. On [redacted]24 at 2:00 pm, during an interview, [Name of Senior Teller at the Credit Union], confirmed: 1. She was the Senior Teller at the time of the incident (could not recall exact date) and took the check to the Branch Manager. She then called R #3's daughter to inform her. She was told by R #3's daughter not to cash the check and confirmed R #3 did not write the check. 3. R #3's account number was changed because they were worried there were other checks that were stolen. 4. DCS #3 was by [redacted]that day and thinks that the female who cashed the other check from R #3's account came in on a different day. 5. The credit union took copies of their ID's because they were not members of the credit union, and confirmed the individual who attempted to cash the check was DCS #3 based on the ID [redacted]presented to the teller at the bank. M. On [redacted]24 at 12:45 pm, during an interview, the Director confirmed: 1. The resident's family came in from out of state after R #3 passed away and notified the facility that there was a problem with the resident's bank account. 2. They (R #3's family) were told by R #3's bank that DCS #3 had gone into the resident's bank with one of the resident's checks and	A 033		

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A 033	Continued From page 16 attempted to cash it. 3. DCS #3 was accompanied by one of [redacted] female friends (non-facility staff) who also cashed a check from the resident's account. N. On [redacted]24 at 1:50 pm, during an interview, [Name of Detective #1] with the Local Police Department confirmed: 1. He (Detective #1) reached out to the facility, spoke to a facility staff (unknown) about the incident, and was told that DCS #3 had already been fired from the facility. 2. The facility was supposed to reach out to him (Detective #1) and notify him if they wanted to press charges against DCS #3. He (Detective #1) confirmed that the facility had not reached out to him.	A 033		