SECOND SET

PRINTED: 03/12/2014
FORM APPROVED

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2214	A. BUILDING: _____ B. WING _____	C 02/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASA DE PAZ	4103 LAS CIMBRAS CT SE RIO RANCHO, NM 87124

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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	7.8.2.32 Reporting of Incidents #1).The violations identified in official statement of deficiency will be corrected by: A). This facility will report all incidents to the appropriate agency within 24 hours, or by the next business day, that have or could threaten the health, safety, or welfare of the residents and staff to the licensing authority complaint hotline. B). Caregiver #1 was terminated effective immediately on 1/15/2014 based on the results of internal investigation. 2).To ensure ongoing compliance all existing caregivers will be retrained with an in-service on incident management. by 4/12/14 this in-service training will be taught and led by our administrator In addition to that, for the health and safety of resident's the administrator will continue to teach and train or direct manager to teach incedent management to all current employees twice annualy every April and October to be completed by every April 30th and October 31st every year.	
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, 7.8.2.33 NMAC,	A 032		

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Division of Health Improvement
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Tiosha Stanley TITLE Administrator (X6) DATE 4/7/14

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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 her forward by her arms to lift her. The resident said "No" as it did hurt her...The resident was clearly upset." The written statement also indicated, "On 01/06/14, she (referring to Caregiver #1) took that	A 032	3). In reference to Section A)., this action will be effective immediately. 4). The incident management training will be put into place within 30 days from the date of the of the notification letter (3/12/2014). So will be completed and implemented by 4/12/2014	

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A 032	Continued From page 2 same resident (referring to Resident #1) to the bathroom...and the caregiver left her in the bathroom and didn't go get her...She (referring to Resident #1) said (Name of Caregiver #1) said she was 'Just going to leave her there all night' and (name of Caregiver #1) did nothing to calm her down and comfort her...she (Caregiver #1) said she (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 Osteoporosis, signs of Dementia, Anxiety, and mobility and ambulation 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 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 her Dementia. 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 her own, or understand when staff were transferring her. My expectation would have been that we as the Administrators be notified immediately but that didn't happen. We were not	A 032		

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A 032	Continued From page 3 notified...She (resident #1) was in fact a two person assist at times, and (name of Caregiver #1) was 'Rushing her.' There was some swelling on her (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 her there. The buzzer (referring to the call light) was going off and she (Caregiver #1) was ignoring her. The resident was in tears and she said (name of Caregiver #1) said she was going to leave her in there. She 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 her wheelchair and she just pulled her by her 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 unresponsive, not interviewable, and very lethargic. 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	A 032		

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A 032	Continued From page 4 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 she was trying to walk into the kitchen...At the time, (name of Resident #2) had a Stye (a inflammatory swelling of one gland of the eyelid) on her eye and (name of Caregiver #1) told her 'No-one wanted here in there touching things because of the nasty Stye she had and to go sit down.' I could tell by the look on (name of Resident #2) face, her feelings had been hurt." 3. Face Sheet (no date) indicated Resident #2 had diagnoses to include Anxiety. 4. Nursing Assessment dated 12/04/13, indicated the resident ambulates (walks independently), sometimes uses a cane, and wanders. It further indicated she has signs of Dementia, signs of Anxiety, and signs of toileting issues requiring minimal assistance from staff. 5. ISP dated 12/04/13 indicated the resident requires minimal assistance from staff with Mobility and needs frequent reminders to use her 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 Dementia. With (name of Resident #2), she has	A 032		

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moderate to severe Dementia, and she wouldn't have known she had a Stye."

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 her to sit down because of the Stye in her eye 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), she had a Stye on her eye and she was walking into the kitchen and (name of Caregiver #1) told her 'Get out of the kitchen. It is nasty.' I could tell by the reaction on her (resident #2) face it hurt her."

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 Stye in her eye. (Name of Caregiver #1) was screaming for her (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 her room and (name of Caregiver #1) told (name of Resident #4) 'Not to help her'. (Name of Resident #3) became very upset and asked (name of Caregiver #1) not to belittle her because

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A 032	Continued From page 6 she is not a child." 2. Face Sheet (no date) indicated diagnoses to include Depression and Anxiety. 3. Nursing Assessment dated 07/05/13, indicated the resident is able to communicate verbally, and has Dementia and Anxiety issues. It further indicated the resident uses a wheelchair and has mobility issues requiring moderate assistance from staff due to poor gait (walking), and weakness. She has transferring issues from a supine to sitting position and sitting to standing and requires moderate assistance. 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 her (resident #3) for what happened. She said she was very upset about it and didn't want to work with (Name of Caregiver #1) again. She is able to verbalize her needs." 2. On 02/13/14, at 9:45 am, during interview, both Administrators stated, (Name of Resident #3) needs physical assistance with her wheelchair. She is a two person transfer and can't bear any weight on her hip." 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 her wheelchair to her room and (Name of Caregiver #1) yelled at (name of Resident #3) and said 'Why should you even ask	A 032		

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A 032	Continued From page 7 him to help you anyway. He 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 she 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 her 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 her, was not nice to her 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, "She (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 his 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 her room and (name of Caregiver #1) told (name of Resident #4) 'Not to help her'. (Name of	A 032		

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A 032	Continued From page 8 Resident #3) became very upset and asked (name of Caregiver #1) not to belittle her because she is not a child. (Name of Caregiver #1) told (name of Resident #3) when she calmed down, she would come help her 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 Dementia. It indicated he has signs of mobility issues to include poor gait, decreased range of motion, uses a wheelchair, and requires minimal assistance from staff, also has transferring issues requiring minimal assistance for supine to sitting position. 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 him to help you anyway. He 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 Resident #3 and #4. (Name of Resident #3) told	A 032		

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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 she 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 Depression and Anxiety.
3. Nursing Assessment dated 10/07/13, indicated the resident has signs of Dementia and Anxiety. Has poor gait and decreased mobility, range of motion and uses a wheelchair.
4. ISP dated 10/07/13, indicated, she 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

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A 032	Continued From page 10 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 Anxiety, Dementia and Agitation. 2. Nursing Assessment dated 12/05/13, indicated, the resident has Frontal Lobe Dementia. 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 kids. I've seen her grab the residents a little	A 032		

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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 directed toward a resident that results and might

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A 032	Continued From page 12 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. E. Employee Abuse Registry 7.1.12 NMAC.	A 070	7.8.2.70 Incorporated and related rules and codes 1). The violations identified in the official statement of deficiency will be corrected by: A). This facility will report all incidents to the appropriate agency within 24 hours, or by the next business day, that have or could threaten the health, safety, or welfare of the residents and staff to the licensing authority complaint hotline.	

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A 070	Continued From page 13 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, feeling belittled, yelled at, and talked to in a demeaning way. This deficient practice has the potential to affect the health, safety, and welfare	A 070	2).To ensure ongoing compliance all existing caregivers will be retrained with an in-service on incident management by 4/12/14 Will be taught and led by Our administrator In addition to that, for the health and safety Of resident's the administrator will continue To teach and train or direct manager To teach incident management to all current Employees twice annually every April and October to be completed by every April 30th and October 31st every year. 3). This facility will continue to ensure that the reporter with direct knowledge of incident has immediate access and knows where to locate the division incident report form at all times and will respond to, report, and document incidents in a timely and accurate manner. 4). In reference to Section A, this action will be effective immediately. 5.)The Incedent Management twice annual training will be put into place within 30 days from the date of the notifcation letter which will be implemented and completed by 4/12/2014	

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A 070	Continued From page 14 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 her forward by her arms to lift her. The resident said "No" as it did hurt her...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 her in the bathroom and didn't go get her...She (referring to Resident #1) said (Name of Caregiver #1) said she was 'Just going to leave her there all night' and (name of Caregiver #1) did nothing to calm her down and comfort her...she (Caregiver #1) said she (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 Osteoporosis, signs of Dementia, Anxiety, and mobility and ambulation issues such as requiring Moderate assistance with using wheelchair. It further indicated the resident has signs of transferring issues from	A 070		

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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), she (the resident) would not have been able to tell you what happened due to her Dementia. 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 her own, 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...She (resident #1) was in fact a two person assist at times, and (name of Caregiver #1) was 'Rushing her.' There was some swelling on her (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 her there. The buzzer (referring to the call light) was going off and she (Caregiver #1) was ignoring her. The resident was in tears and she said (name of Caregiver #1) said she was going to leave her in there. She 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

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A 070	Continued From page 16 Resident #1) out of her wheelchair and she just pulled her by her 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 unresponsive, not interviewable, and very lethargic. 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 she was trying to walk into the kitchen...At the time, (name of Resident #2) had a Stye (a inflammatory swelling of one gland of the eyelid) on her eye and (name of Caregiver #1) told her 'No-one wanted here in there touching things because of the nasty Stye she had and to go sit down.' I could tell by the look on (name of Resident #2) face her feelings had been hurt." 3. Face Sheet (no date) indicated Resident	A 070		

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A 070	Continued From page 17	A 070		

#2 had diagnoses to include Anxiety.

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 Dementia, signs of Anxiety, signs of toileting issues requiring minimal assistance from staff.

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 Dementia. With (name of Resident #2) she has moderate to severe Dementia, and she wouldn't have known she had a Stye."

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 her to sit down because of the Stye in her eye 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), she had a Stye on her eye and she was walking into the kitchen and (name of Caregiver #1) told her 'Get out of the kitchen. It is nasty.' I

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A 070	Continued From page 18 could tell by the reaction on her (resident #2) face it hurt her. 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 Stye in her eye. (Name of Caregiver #1) was screaming for her (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 her room and (name of Caregiver #1) told (name of Resident #4) 'Not to help her'. (Name of Resident #3) became very upset and asked (name of Caregiver #1) not to belittle her because she is not a child. (Name of Caregiver #1) told (name of Resident #3) when she calmed down, she would help her and closed the door and left the room." 2. Face Sheet (no date) indicated diagnoses to include Depression and Anxiety. 3. Nursing Assessment dated 07/05/13, indicated she is able to communicate verbally, has Dementia issues, and Anxiety issues. It further indicated the resident uses a wheelchair and has mobility issues requiring moderate assistance from staff due to poor gait (walking), and weakness. She has transferring issues from a supine to sitting position and sitting to standing and requires moderate assistance. 4. ISP dated 09/29/13, indicated the resident	A 070		

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A 070	Continued From page 19 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 her for what happened. She said she was very upset about it and didn't want to work with (Name of Caregiver #1) again. She is able to verbalize her needs." 2. On 02/13/14 at 9:45 am, during interview, both Administrators stated, (Name of Resident #3) needs physical assistance with her wheelchair. She is a two person transfer and can't bear any weight on her hip." 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 her wheelchair to her room and (Name of Caregiver #1) yelled at (name of Resident #3) and said 'Why should you even ask him to help you anyway. He 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 she 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 her 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 her, was not nice to her 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	A 070		

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A 070	Continued From page 20 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 she 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 him to be in a wheelchair and able to make his 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 her room and (name of Caregiver #1) told (name of Resident #4) 'Not to help her'. (Name of Resident #3) became very upset and asked (name of Caregiver #1) not to belittle her because she is not a child. (Name of Caregiver #1) told (name of Resident #3) when she calmed down...she 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 Dementia. It indicated he has signs of mobility issues to include poor gait, decreased range of motion, uses a wheelchair, and requires minimal assistance from staff, also has transferring issues requiring minimal assistance for supine to sitting position. 4. ISP dated 12/05/13 indicated he uses a	A 070		

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A 070	Continued From page 21 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 him to help you anyway. He 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, "She was upset about the situation and she 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 said, "I have nothing else to say about it." Resident #6	A 070		

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A 070	Continued From page 22 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 Depression and Anxiety. 3. Nursing Assessment dated 10/07/13, indicated she has signs of Dementia, signs of Anxiety, and has poor gait and decreased mobility, range of motion and and uses a wheelchair. 4. ISP dated 10/07/13 indicated, she 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." 2. On 02/13/14 at 8:40 am, during interview, both Administrators stated, "One resident (referring to Resident #6) told me she (Caregiver	A 070		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 070	Continued From page 23 #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 Anxiety, Dementia and Agitation. 2. Nursing Assessment dated 12/05/13 indicated, the resident has Frontal Lobe Dementia. 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). Q. On 02/13/14 at 8:40 am, during interview, both Administrators indicated that on 12/13/13, "We	A 070		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2214	A. BUILDING: _____ B. WING _____	C 02/13/2014

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A 070	Continued From page 24 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... T. Review of the facility Employee Conduct Policy (no date) indicated, "All staff members will conduct themselves in a professional	A 070		

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A 070	Continued From page 25 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		