Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2035	A. BUILDING _____ B. WING _____	C 11/08/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WORKER BEE LLC	404 NORTH LOCKE FARMINGTON, NM 87401

(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 A Complaint investigation was completed for intake #NM00027565 for NMAC 7.8.2 regulations governing Assisted Living facilities. The Complaint was Substantiated for allegation of Abuse with deficiencies cited. Alleged perpetrator was referred for placement on the Employee Abuse Registry.	A 000		
A 013	7 NMAC 8.2.13 Grounds for Revocatio, Suspension or Denial GROUNDS FOR REVOCATION, SUSPENSION OR DENIAL OF INITIAL OR RENEWAL OF LICENSE, OR THE IMPOSITION OF SANCTIONS OR CIVIL MONETARY PENALTIES: A. When the licensing authority determines that an application for the renewal of a license will be denied or that a license will be revoked, the licensing authority shall provide written notification to the facility, the residents and the surrogate decision makers for the residents. B. After notice to the facility and an opportunity for a hearing, the department may deny an initial or renewal application, revoke or suspend the license of a facility or may impose an intermediate sanction and a civil monetary penalty as provided in accordance with the Public Health Act, Section 24-1-5.2 NMSA 1978. C. Grounds for implementing these penalties may be based on the following: (1) failure to comply with any provision of this rule; (2) failure to allow a survey by authorized representatives of the licensing authority; (3) the hiring or retaining of any staff or permitting any private duty attendant or volunteer to work with residents that has a disqualifying conviction	A 013		

scanned 10.17.11 CP

RECEIVED OCT HEALTH FACILITY LICENSING & CERTIFICATION BUREAU

Jeli Johnson
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE: Administrator

(X6) DATE: 10-6-11

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A 013	Continued From page 1 under the requirements of the Caregiver ' s Criminal History Screening Program, 7.1.9 NMAC; (4) the misrepresentation or falsification of any information on the application forms or other documents provided to the licensing authority; (5) repeat violations of this rule; (6) failure to maintain or provide services as required by this rule; (7) exceeding licensed capacity; (8) failure to provide an acceptable plan of correction within the time period established by the licensing authority; (9) failure to correct deficiencies within the time period established by the licensing authority; (10) failure to comply with the incident reporting requirements pursuant to Incident Reporting, Intake Processing and Training Requirements, 7.1.13 NMAC; and (11) failure to pay civil monetary penalties pursuant to Health Facility Sanctions and Civil Monetary Penalties, 7.1.8 NMAC. [7.8.2.13 NMAC - Rp, 7.8.2.13 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: Refer to 7.8.2.13 - GROUNDS FOR REVOCATION OR SUSPENSION OF LICENSE, DENIAL OF INITIAL OR RENEWAL APPLICATION FOR LICENSE, OR IMPOSITION OF INTERMEDIATE SANCTIONS OR CIVIL MONETARY PENALTIES: B. A license may be revoked or suspended, an initial or renewal application for license may be denied, or intermediate sanctions or civil monetary penalties may be imposed after notice and opportunity for a hearing AND	A 013		

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A 013	Continued From page 2 C. Grounds for implementing these penalties may be based on the following: 1. failure to comply with provisions of this rule: and 6. failure to provide services as required by this rule 7.8.2.7 - Definitions AW. " Neglect " means the failure to provide goods and services necessary to avoid physical harm, mental anguish or mental illness and is defined in the Incident Reporting Intake, Processing & Training Requirements, 7.1.13 NMAC. Based on record review and interviews, the facility failed to ensure that necessary number of staffing was provided to the population of this facility to avoid physical harm for (Resident #1) resident. The findings are: A. Review of Intake #NM00027565 revealed concerns surrounding an incident in which a resident took a hard fall to the floor that resulted in an arm fracture. B. On 10/26/10 at 12:00 pm, during an interview, Interviewee #1 revealed that the facility Administrator and Manager #1 have given apparent conflicting accounts about what happened during the fall of Resident #1. First, the facility said that Resident #1 "fell hard to the floor with the resident, landing with the resident's arm behind her." Then at a later time, Interviewee #1 was also told that Resident #1's legs gave out from lack of firm pressure during	A 013	7.8.2.13 please see attatched timecard documents showing there were 2 caregivers on duty at the time the incident occured. The facility administratw will continue to ensure ample number of staff on duty to provide for facility's residents needs. The facility administrator will review resident's care plan and ensure staff are trained and understand that plan and how to carry out that plan. In addition, facility administrator will conduct an internal audit of all facitily residents care plans and ensure all care plans are up to date and accurate. An inservice	

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A 013	Continued From page 3 toileting and fell over (unaided). Interviewee #1 reported that due to a previous stroke (status post CVA), Resident #1's left side was contracted, which greatly limited the resident's ability to toilet without assistance. There was no documentation of an investigation with all involved parties that would clarify these varying accounts for accuracy. C. On 10/26/10 at 3:08 pm, during an interview with Resident #1, she reported clearly that she remembered the fall earlier in the year that sent her to the hospital. Resident #1 reported that "she (Staff #1) was supposed to be holding me and let me fall. I broke my arm and hurt my shoulder." D. On 11/04/10 at 11:38 am, during an interview with Resident #1's primary physician, he reported that he was told of the fracture of the left shoulder during a routine appointment subsequent to the occurrence of the incident. He reported that Resident #1 was sufficiently mentally clear according to notes he took during last visits indicating that Resident #1 could both recall and recant an accurate version how the fall and fracture occurred. E. On 11/4/10 at 9:50 am, during an interview, the Administrator reported that neither she or the Manager had any documentation drafted or signed by the alleged abuser, other staff on duty at the time, or other interviews that would indicate recollection of the incident as part of an facility internal investigation. Administrator did report that Caregiver #1 should not have assisted Resident #1 alone due to the weakness of Resident #1's left side. Finally, no documentation was provided that indicated that the staff on duty at the facility at the time of the incident had been interviewed	A 013	will be conducted for all staff concerning These ISP's. The facility administrator will ensure all staff are trained in and understand the implementation of each residents care plan. The facility RN and administrator will continually monitor care plans and ensure updated training for staff whenever a change is made in care plan due to a change in a residents care needs. This deficiency is corrected as of 9/29/2011	

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A 013	Continued From page 4 and notes documented. Finally, no documented interview was provided with what the Resident #1 to had to say regarding the incident. F. Subsequent interview with Manager on 11/08/10 revealed that Resident #1 had reported that she had been dropped by Staff #1 but the Manager acknowledged that she did not document that interview with the resident. G. Interview with the Manager on 10/26/10 revealed that Caregiver #1 was trained that Resident #1 was a two-person transfer. And while she reports that she was not at the facility at the time of the fall, but reported that Resident #1 was being assisted by Staff #1 alone because Resident #1 had shared that information with her.	A 013		
A 021	7 NMAC 8.2.21 Resident Records RESIDENT RECORDS: A. Record contents. A record for each resident shall be maintained in accordance with the specific requirements of this section. Entries in each resident's record shall be legible, dated and authenticated by the signature of the person making the entry. Resident records shall be readily available on site and organized utilizing a table of contents. Each resident record shall include: (1) the admission agreement records, as set forth in 7.8.2.20 NMAC; (2) the resident evaluation form, that is to be completed within fifteen (15) days prior to admission and updated at a minimum of every six (6) months; (3) the current ISP, that is to be completed within ten (10) calendar days of admission and updated at a minimum of every six (6) months; (4) the physical examination report; the physical	A 021		

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A 021	Continued From page 5 examination report shall have been completed within the past six (6) months, by a primary care physician, a nurse practitioner or a physician ' s assistant and shall be on file in the resident ' s record within ten (10) days of admission; (5) personal and demographic information for the resident, to include: (a) current names, addresses, relationship and phone numbers of family members, or surrogate decision makers updated as necessary; (b) resident's name; (c) age; (d) recent photograph; (e) marital status; (f) date of birth; (g) sex; (h) address prior to admission; (i) religion (optional); (j) personal physician; (k) dentist; (l) social history; (m) surrogate decision maker or other emergency contact person; (n) language spoken and understood; (o) legal documentation relevant to commitment or guardianship status; (p) current medications list; and (q) required diet; (6) unless included in the admission agreement, a separate written agreement between the facility and the resident relating to the resident's funds, in accordance with the facility's policy and procedures; (7) entries by direct care staff, appropriate health care professionals and others authorized to care for the resident; entries shall be dated and signed by the person making the entry and shall include significant information related to the ISP; (8) entries that provide a written account of all accidents, injuries, illnesses, medical and dental	A 021		

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A 021	Continued From page 6	A 021		

appointments, any problems or improvements observed in the resident, any condition that would indicate a need for alternative placement or medical attention and entries reflecting appropriate follow-up; the maintenance of such written documentation in the resident record may be by copy of an incident or accident report, if the original incident or accident report is maintained elsewhere by the facility;
(9) the medication assistance record (MAR); the MAR is the document that details the resident's medication; the MAR shall include all of the information pursuant to Subsection G of 7.8.2.35 NMAC of this rule;
(10) progress notes completed by any contract agency (e.g., hospice, home health); the progress notes shall include the date, time and type of health services provided;
(11) copies of all completed and signed transfer forms from the accepting facility when a resident is transferred to a hospital or another health care facility and when the resident is transferred back to the facility; and
(12) upon the death or transfer of a resident, documentation of the disposition of the resident's personal effects and money or valuables that are deposited with the assisted living facility.
B. Resident records maintenance.
(1) Current resident records shall be maintained on-site and stored in an organized, accessible and permanent manner.
(2) The facility shall establish a policy to maintain and ensure the confidentiality of resident records, including the authorized release of information from the resident records.
(3) Non-current resident records shall be maintained by the facility against loss, destruction and unauthorized use for a period of not less than five (5) years from the date of discharge and readily available within twenty-four (24) hours of

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A 021	Continued From page 7 request. (4) There shall be a policy and procedure in place for record retention in the event of facility closure. (5) Failure to follow facility policies is grounds for sanctions. [7.8.2.21 NMAC - Rp, 7.8.2.22 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: Refer to 7.8.2.21(A)(8) - RESIDENT RECORDS: Record contents. A record for each resident shall be maintained in accordance with the specific requirements of this section. Entries in each resident's record shall be legible, dated and authenticated by the signature of the person making the entry. Resident records shall be readily available on site and organized utilizing a table of contents. Each resident record shall include: (8) entries that provide a written account of all accidents, injuries, illnesses, medical and dental appointments, any problems or improvements observed in the resident, any condition that would indicate a need for alternative placement or medical attention and entries reflecting appropriate follow-up; the maintenance of such written documentation in the resident record may be by copy of an incident or accident report, if the original incident or accident report is maintained elsewhere by the facility. Based on record review and interviews, the facility failed to maintain documentation of fall incident requiring medical intervention for one facility resident (Resident #1). The findings are:	A 021	7.8.2.21 (A) (8) This facility will properly document all accidents, injuries, illnesses, medical and dental appointments, any problems or improvements observed in the resident, and any condition that would indicate a need for alternate placement or medical attention. The facility will also follow through with documentation and assure appropriate persons are notified. Such documentation will be done each shift by the staff member on duty. Updated care plans will be reviewed and approved by facility RN. This deficiency is corrected as of 9/29/2011	

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A 021	Continued From page 8 A. Review of Intake #NM00027565 revealed concerns surrounding an incident in which a resident took a hard fall to the floor that resulted in an arm fracture. B. On 10/26/10 at 12:00 pm, during an interview, Interviewee #1 revealed that the facility Administrator and Manager #1 have given apparent conflicting accounts about what happened during the fall of Resident #1. First, the facility said that Resident #1 "fell hard to the floor with the resident, landing with the resident's arm behind her." Then at a later time, Interviewee #1 was also told that Resident #1's legs gave out from lack of firm pressure during toileting and fell over (unaided). Interviewee #1 reported that due to a previous stroke (status post CVA), Resident #1's left side was contracted, which greatly limited the resident's ability to toilet without assistance. There was no documentation of an investigation with all involved parties that would clarify these varying accounts for accuracy. C. On 10/26/10 at 3:08 pm, during an interview with Resident #1, she reported clearly that she remembered the fall earlier in the year that sent her to the hospital. Resident #1 reported that "she (Staff #1) was supposed to be holding me and let me fall. I broke my arm and hurt my shoulder." D. On 11/04/10 at 11:38 am, during an interview with Resident #1's primary physician, he reported that he was told of the fracture of the left shoulder during a routine appointment subsequent to the occurrence of the incident. He reported that Resident #1 was sufficiently mentally clear according to notes he took during last visits indicating that Resident #1 could both recall and	A 021		

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A 021	Continued From page 9 recant an accurate version how the fall and fracture occurred. E. On 11/4/10 at 9:50 am, during an interview, the Administrator reported that neither she or the Manager had any documentation drafted or signed by the alleged abuser, other staff on duty at the time, or other interviews that would indicate recollection of the incident as part of an facility internal investigation. Administrator did report that Staff #1 should not have assisted Resident #1 alone due to the weakness of Resident #1's left side. Finally, no documentation was provided that indicated that the staff on duty at the facility at the time of the incident had been interviewed and notes documented. Finally, no documented interview was provided with what the Resident #1 to had to say regarding the incident. G. Interview with the Manager on 10/26/10 revealed that Staff #1 was trained that Resident #1 was a two-person transfer. And while she reports that she was not at the facility at the time of the fall, but reported knowledge that Resident #1 was being assisted by Staff #1 alone. F. Subsequent interview with Manager on 11/08/10 revealed that Resident #1 had reported that she had been dropped by Caregiver #1 but the Manager acknowledged that she did not document that interview with the resident. Again, there was no documentation of an investigation with all involved parties that would clarify these varying accounts of the situation.	A 021	7.1.138 (B)(2) This facility understood an incident report had been filed with the state. A facility employee filled out the incident report and reported to management that the report had been faxed the same day the incident occured. The incident report is available at the facility. The facility administrator will conduct a staff inservice concerning incident reporting that will properly train and (retrain staff) concerning all aspects of proper incident reporting intake, processing and training requirements.	
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	A 070		

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A 070	Continued From page 10 are also subject to other rules, codes and standards that may, from time to time, be amended. This includes the following: A. Health Facility Licensure Fees and Procedures, New Mexico Department of Health, 7.1.7 NMAC. B. Health Facility Sanctions and Civil Monetary Penalties, New Mexico Department of Health, 7.1.8 NMAC. C. Adjudicatory Hearings for Licensed Facilities, New Mexico Department of Health, 7.1.2 NMAC. D. Caregiver's Criminal History Screening Requirements, 7.1.9 NMAC. E. Employee Abuse Registry 7.1.12 NMAC. F. Incident Reporting, Intake Processing and 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 NMAC 7.1.13.8 (B)(2) - Incident Reporting, Intake, Processing and Training Requirements - Division Incident Report Form and Notification by Licensed Health Care Facilities "The licensed health care facility shall ensure all incident report forms alleging abuse, neglect or misappropriation of consumer property submitted by the reporter with direct knowledge of an incident are completed on the division's incident report form and received by the division within twenty-four (24) hours of an incident or allegation of an incident or the next business day if the incident occurs on a weekend or a holiday. The licensed health care facility shall ensure that the reporter with the most direct knowledge of the incident prepares the incident report form." AND	A 070	This facility understands the importance of proper incident reporting and will ensure reports are filed with the state authority in a proper and timely matter. This deficiency is corrected as of 9/29/2011	

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A 070	Continued From page 11 Refer to NMAC 7.1.13.8 (F) - Incident Reporting, Intake, Processing and Training Requirements - Quality Improvement System for License Health Care Facilities "The provider shall maintain documented evidence that all alleged violations are thoroughly investigated, and shall take all reasonable steps to prevent further incidents." Based on record review and interview, the facility failed to ensure that an incident was reported to the licensing authority as required for 1 of 12 residents (Resident #1). The facility also failed to thoroughly investigate the incident. The findings are: A. Complaint Intake Report #NM00027565 revealed concerns surrounding an incident in which a resident took a hard fall to the floor that resulted in an arm fracture. B. On 10/26/10 at 12:00 pm, during an interview, Interviewee #1 revealed that the facility Administrator and Manager #1 have given apparent conflicting accounts about what happened during the fall of Resident #1. First, the facility said that Resident #1 "fell hard to the floor with the resident, landing with the resident's arm behind her." Then at a later time, Interviewee #1 was also told that Resident #1's legs gave out from lack of firm pressure during toileting and fell over (unaided). Interviewee #1 reported that due to a previous stroke (status post CVA), Resident #1's left side was contracted, which greatly limited the resident's ability to toilet without assistance. There was no documentation of an investigation with all involved parties that would clarify these varying accounts for accuracy. C. On 10/26/10 at 3:08 pm, during an interview	A 070		

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A 070	Continued From page 12 with Resident #1, she reported clearly that she remembered the fall earlier in the year that sent her to the hospital. Resident #1 reported that "she (Caregiver #1) was supposed to be holding me and let me fall. I broke my arm and hurt my shoulder." D. On 11/04/10 at 11:38 am, during an interview with Resident #1's primary physician, he reported that he was told of the fracture of the left shoulder during a routine appointment subsequent to the occurrence of the incident. He reported that Resident #1 was sufficiently mentally clear according to notes he took during last visits indicating that Resident #1 could both recall and recant an accurate version how the fall and fracture occurred. E. On 11/4/10 at 9:50 am, during an interview, the Administrator reported that neither she or the Manager had any documentation drafted or signed by the alleged abuser, other staff on duty at the time, or other interviews that would indicate recollection of the incident as part of an facility internal investigation. Administrator did report that Staff #1 should not have assisted Resident #1 alone due to the weakness of Resident #1's left side. Finally, no documentation was provided that indicated that the staff on duty at the facility at the time of the incident had been interviewed and notes documented. Finally, no documented interview was provided with what the Resident #1 to had to say regarding the incident. F. Interview with the Manager on 10/26/10 revealed that Caregiver #1 was trained that Resident #1 was a two-person transfer. And while she reports that she was not at the facility at the time of the fall, but reported that Resident #1	A 070		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2035	A. BUILDING _____ B. WING _____	C 11/08/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WORKER BEE LLC	404 NORTH LOCKE FARMINGTON, NM 87401

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A 070	Continued From page 13 was being assisted by Staff #1 alone because Resident #1 had shared that information with her. G. Subsequent interview with Manager on 11/08/10 revealed that Resident #1 had reported that she had been dropped by Caregiver #1 but the Manager acknowledged that she did not document that interview with the resident. Again, there was no documentation of an investigation with all involved parties that would clarify these varying accounts of the situation. H. Review of the incident database revealed that, to date, the fall incident had not been reported to the Department of Health as required.	A 070		