Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2162	A. BUILDING: _____ B. WING _____	R-C 09/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE TRAMWAY RIDGE #2	4910 TRAMWAY RIDGE DRIVE NE ALBUQUERQUE, NM 87111

(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
{8 000}	Initial Comments The following deficiency was cited during an offsite Revisit/Follow-up survey completed on 09/26/25 for the state requirements of NMAC 8.370.14, Regulations for Assisted Living for Adults. Resident Census: 60	{8 000}		
{8 032}	8 NMAC 370.14.32 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 8.370.9 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 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 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 8.370.9 NMAC; and (3) plans for further actions in response to the incident.	{8 032}	Rule: 8032 - 8 NMAC 370.14.32 Reporting of Incidents: Executive Director / Health and Wellness Director Complete Date: 10/17/2025 Correction on a permanent basis: All resident falls especially with any perceived injury will be reported to state within 24 hours, and an investigation will be conducted and reported within 5 business days. On 10/17/2025 all managers and care staff were educated on the regulation that any fall must be reported to the state. To ensure ongoing compliance, the Executive Director will conduct audits of internal incident reports with state incident reports for the next 6 months to ensure all falls especially with injury are being reported. Also, the Executive Director receives all community reports and will ensure the timeliness of the submitted state reports.	10/17/2025

Division of Health Improvement
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Cyfon Dixley TITLE Executive Direc. (X6) DATE 10/17/25

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{8 032}	Continued From page 1 [8.370.14.32 NMAC - N, 7/1/2024] This REQUIREMENT is not met as evidenced by: 8.370.14.32 A (1) REPORTING OF INCIDENTS: A. The facility shall ensure (to make certain that something shall occur or be the case) that all suspected cases or known incidents of resident abuse, neglect or exploitation are reported in accordance with 8.370.9 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. (3) All licensed health care facilities shall ensure that the reporter with direct knowledge of an incident has immediate access to the bureau incident report form to allow the reporter to respond to, report, and document incidents in a timely and accurate manner. 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. Based on record review and interview, the facility failed to ensure for 8 (R #'s 1-8) of 8 (R's 1-8) residents whose incident reports were reviewed for compliance that incidents were reported within twenty-four (24) hours to the Licensing Authority	{8 032}		

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{8 032}	Continued From page 2	{8 032}		

(LA), nor was an investigation conducted within five (5) business days and reported to the LA.

These deficient practices could impede (delay or prevent) regulatory oversight and hinder (create difficulties resulting in delay) the identification of care trends or patterns that may affect resident outcomes.

The findings are:

A. Record review of the facility's internal incident report dated [redacted]/25 revealed R #1 had an unwitnessed fall with a [redacted] and it was not reported to the LA within 24 hours and an investigation was not conducted within five (5) business days and reported to the LA.

B. Record review of the facility's internal incident report dated [redacted]25 revealed R #2 had a witnessed fall with a [redacted] and it was not reported to the LA within 24 hours. A Follow-up report was submitted to the LA on [redacted]/25 but no initial report that was linked to it. (Not connected or associated).

C. Record review of the facility's internal incident report dated [redacted]25 revealed R #3 had a witnessed fall with no visible injury but resident complained of [redacted] and it was not reported to the LA within 24 hours and an investigation was not conducted within five (5) business days and reported to the LA.

D. Record review of the facility's internal incident report dated [redacted]/25 revealed R #4 had a witnessed fall with [redacted] and it was not reported to the LA within 24 hours and an investigation was not conducted within five (5)

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{8 032}	Continued From page 3 business days and reported to the LA. E. Record review of the facility's internal incident report dated [redacted]/25 revealed R #5 had a witnessed fall with [redacted] and it was not reported to the LA within 24 hours and an investigation was not conducted within five (5) business days and reported to the LA. F. Record review of the facility's internal incident report dated [redacted]/25 revealed R #6 was [redacted], unwitnessed by staff and it was not reported to the LA within 24 hours and an investigation was not conducted within five (5) business days and reported to the LA. G. Record review of the facility's internal incident report dated [redacted]/25 revealed R #7 had a witnessed fall with a [redacted] and it was not reported to the LA within 24 hours and an investigation was not conducted within five (5) business days and reported to the LA. H. Record review of the facility's internal incident report dated [redacted]/25 revealed R #8 had a witnessed fall with no visible injury but complained of [redacted] and it was not reported to the LA within 24 hours and an investigation was not conducted within five (5) business days and reported to the LA. I. Record review of the facility's internal incident report dated [redacted]25 revealed R #6 had a witnessed fall with no signs of injury due to [redacted] and it was not reported to the LA within 24	{8 032}		

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{8 032}	Continued From page 4 hours and an investigation was not conducted within five (5) business days and reported to the LA. J. On 09/26/25 at 3:18 PM, during an interview, the Administrator confirmed the incidents were not reported to the LA within 24 hours and an investigation was not conducted within five (5) business days and reported to the LA.	{8 032}		