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 _____	C 09/27/2024

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 a Complaint survey completed on 09/27/24 for the state requirements of 8.730.14 NMAC, Regulations for Assisted Living for Adults. Census: 49 Complaint Intake NM [redacted] was investigated, and deficiencies were cited. Complaint Intake NM [redacted] was investigated, and deficiencies were not cited.	8 000	The following plan of correction for Brookdale Tramway ridge regarding the statement of deficiencies dated September 27, 2024. This plan of correction is not to be construed as an admission of or agreement with findings and conclusion in the statement of deficiencies or any related sanction or fine. Rather, it is submitted as confirmation of our ongoing efforts to comply with statutory and regulations. In this document, we have outlined specific actions in response to each allegation or findings nor have we identified mitigating factors. We remain committed to the delivery of quality healthcare services and will continue to make changes and improvement to satisfy that objective.	
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	8 032	A) The community will insure that all suspected cases or know incidents of resident abuse, neglect or exploitation are reported in accordance with 7.1.13. NMAC 1) The community will report any incidents or unusual occurrence which has or could threaten the health, safety or welfare of the resident within 24 hours. 2) The community will not delay a report to the Complain hotline while an internal investigation is conduct 3) The community will be conducting the investigation of all incidents with 5 business days and will summit a copy of the investigation report to the licensing authority. 4) Community will conduct description of the incident 5) The result of the investigation will be recorded on the state approved incident report form for the current year 6) Completion date 12/02/24 7) Health and wellness director (DON) will complete investigation.	

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Executive Director — (X6) DATE: 11-18-24

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8 032	Continued From page 1 form for the current year, pursuant to 8.370.9 NMAC; and (3) plans for further actions in response to the incident. [8.370.14.32 NMAC - N, 7/1/2024] This REQUIREMENT is not met as evidenced by: 8.370.14.32 A (1) and B REPORTING OF INCIDENTS: A. The facility shall ensure 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.	8 032		

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8 032	Continued From page 2 Based on record review and interview, the facility failed to ensure that: 1. The facility reported incidents of unusual occurrence that had or could threaten the health, safety, or welfare of the residents to the Licensing Authority within twenty-four (24) hours or by the next business day if it is a weekend or a holiday. 2. Conducted an internal investigation and submitted an investigation follow-up report to the Licensing Authority (LA) within five (5) business days from when an incident occurred. These deficient practices could likely result in the 49 (R #s 1-49) residents listed on the resident census provided by the Business Office Manager on 09/23/24, to be at risk of harm, injury, and/or death if there an unusual occurrence and it is not reported to the Licensing Authority. The findings are: A. Record review of complaint intake [redacted] received on 04/30/24 revealed on [redacted] at 8:57 pm, the complainant received a voicemail from the Resident Care Coordinator (RCC) stating that R #1 was "outside in the street, saying she wanted to get hit by a car." B. Record review of facility's progress notes for R #1 revealed: 1. An entry dated [redacted] at 7:15 pm by Direct Care Staff (DCS) #3 stated, "resident approached 2nd floor nurses station and said, 'my stay here was wonderful, but its time for me to leave.' Resident went down the stairs as carestaff tried to redirect her. I decided to take her for a walk to help calm her down. We walked outside where she immediately walked towards [name of road]. I held her hand and told her it was safer if we walked to our left instead. Resident	8 032		

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8 032	Continued From page 3 agreed. Resident was crying and yelling 'take me out of this world already' 'take me out now.' As we were coming to the stop sign, she picked up her pace and walked directly in front of a moving car coming from the South [SIC]. Resident was not injured or harmed. I called [name of memory care] med-tech to come help me. Med-Tech and Maintenance [name of maintenance personnel] came and helped calm her down. [name of maintenance personnel] was able to talk her into coming back into the building. On-Call was notified and Med-Tech was notified. Resident was taken back to [room #]. Resident was then monitored outside her room by carestaff incase she tried to come out from her room again. Resident was then moved to third floor approx.: 9:40 pm." 2. An entry dated [redacted] at 10:30 pm by the Former Nurse stated, "This resident was taken for a walk outside by caregiver. Caregiver reported that the patient was trying to go in front of cars and wanted to leave. The resident was safely brought back inside and sent to her room. Spoke with on-call manager. This resident was moved to third floor for safety and elopement (leaving the facility unaccompanied) risk. The resident's daughter is aware of the situation." 3. An entry date [redacted] at 12:30 pm by Resident Care Coordinator (RCC) #2 stated, "Resident was having behaviors and panicking, she was on the third floor balcony stating she wanted to jump out the balcony window and die also started crying and having severe agitation wanting to see her daughter and ED [Executive Director] was notified and they decided to take her home that day." C. On 09/25/24 at 3:03 pm, during an interview, the Administrator confirmed the incidents on [redacted] and [redacted] were not reported to the	8 032		

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8 032	Continued From page 4 Licensing Authority. D. Record review of complaint intake [redacted] received on 09/19/24 revealed for the past month the third floor was having issues of not having any water or the water pressure was very low. E. On 09/24/24 during an interview, the complainant stated: 1. She visits the facility approximately three times a week to visit her family member and became aware of the low water pressure at the facility in mid August 2024. 2. Since then the water has worked in the facility intermittently (steadily), sometimes the water just trickling out of the faucet or there is not enough water to flush the toilet. 3. She was made aware of the ongoing water pressure issues during her weekly visits and also read about it in the facility's weekly newsletter. F. On 09/25/24 during an interview, the Maintenance Director stated: 1. He received a maintenance request for low water pressure in a resident's room on the third floor on 08/14/24. 2. Upon responding to the maintenance request, he discovered that one of the two water booster pumps which supply water pressure to the third floor was not working. 3. On 08/20/24, the local pluming company was able to install a temporary pump which was undersized to produce the amount of pressure needed and caused the pump to overheat. 4. The facility was able to bring and store 5-gallon buckets of water from the memory care building to assist in flushing toilets and provide bottled drinking water to the residents. 5. Some residents were able to shower on the lower levels of the building and in the	8 032		

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8 032	Continued From page 5 separate memory care building. G. On 09/25/24 at 3:10 pm, during an interview, the Administrator confirmed the incidents related to water pressure were not reported to the Licensing Authority.	8 032		