STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2055	A. BUILDING: _____ B. WING _____	C 03/12/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE VALENCIA	300 VALENCIA DRIVE SE ALBUQUERQUE, NM 87108

(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 deficiency was cited during a Complaint survey completed on 03/12/20 for the state requirements of 7 MAC 8.2, Regulations for Assisted Living. Complaint Intake #42349 was unsubstantiated 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 NMAC; and (3) plans for further actions in response to the	A 032		

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A 032	Continued From page 1 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 & 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 division within twenty-four (24) hours of an incident or allegation of an incident or the next	A 032		

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A 032	Continued From page 2	A 032		

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 2 (R #s 5 and 7) of 9 (R #s 1-9) residents whose resident files were reviewed for compliance that incidents of unusual occurrence, that could likely threaten the health, safety, or welfare of the residents were reported to the Licensing Authority within twenty-four (24) hours or the next business day if on a holiday or weekend.

This deficient practice could likely cause all residents to be at risk of harm, injury, and/or death, if there is no oversight by the Licensing Authority. The findings are:

A. Record Review of the facility's incident reports for R #5, revealed that on 10/24/19 the resident had a witnessed fall resulting in injury to the lower back/spine and lower right leg. This incident was recorded but not reported to the Licensing Authority within 24 hours or the next business day if a weekend or holiday.

B. Record review of the facility's incident report files for R #7, revealed the following incidents were not reported to the Licensing Authority within 24 hours or the next business day if a weekend or holiday:

1. 01/26/20 - unwitnessed fall with head injury, scrape/abrasion.

2. 12/22/19 - unwitnessed fall with pain in the right rib.

3. 11/02/19 - unwitnessed fall with bump to left side of head, left hand, left temporal area, left

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A 032	Continued From page 3 wrist. 4. 11/02/19 - unwitnessed fall with bump on the head, right elbow, lower right leg, occipital area of the head (the back of the head near the Occipital Lobe). 5. 09/24/19 - unwitnessed fall with possible fracture/awaiting x-rays. C. On 03/12/20 at 10:10 am, during an interview with Director of Assisted Care, she confirmed that the above listed incidents for R #s 5 & 7 were not reported to the Licensing Authority within 24 hours or the next business day if a weekend or holiday.	A 032		