| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 4028 | A. BUILDING: _____ B. WING _____ | C 09/07/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| MORNINGSTAR OF ALBUQUERQUE | 8051 PALOMAS AVE NE ALBUQUERQUE, NM 87109 |

| (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 |
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| A 000 | Initial Comments<br><br>The following deficiencies were cited during a Complaint survey conducted 09/07/22, for the state requirements of 7 NMAC 8.2, Regulations for Assisted Living Facilities for Adults.<br><br>Complaint NM #58848 was Unsubstantiated with deficiencies cited.<br>Complaint NM #59569 was Unsubstantiated with no deficiencies cited.<br>Complaint NM #48469 was Unsubstantiated with no deficiencies cited.<br>Complaint NM #54258 was Unsubstantiated with no deficiencies cited.<br>Complaint NM #61121 was Unsubstantiated with no deficiencies cited.<br>Complaint NM #52132 was Unsubstantiated with no deficiencies cited. | A 000 | | |
| A 032 | 7 NMAC 8.2.32 Reporting of Incidents<br><br>REPORTING OF INCIDENTS:<br>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.<br>(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.<br>(2) The facility shall not delay a report to the complaint hotline while an internal investigation is conducted.<br>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 | A 032 | | |

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| A 032 | Continued From page 1<br>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:<br>(1) a narrative description of the incident;<br>(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<br>(3) plans for further actions in response to the incident.<br>[7.8.2.32 NMAC - Rp, 7.8.2.32 NMAC, 01/15/2010]<br><br>This REQUIREMENT is not met as evidenced by:<br>7.8.2.32 A (1) B<br>7.1.13 INCIDENT REPORTING, INTAKE, PROCESSING AND TRAINING REQUIREMENTS<br><br>Refer to 7.1.13.7 W. & 8 B. (2)<br><br>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.<br><br>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 | A 032 | A032<br><br>Albuquerque September 2022 Survey Plan of Correction<br>A 032<br>7 NMAC 8.2.32 Reporting of Incidents<br><br>A) With respect to HOW the facility will CORRECT the problem identified in the deficiency list:<br>1. Executive Director (ED) or designee will review all incident reports dating back 60 days and ensure all reportable incidents have been reported to the NMDOH in accordance with occurrence reporting guidelines. This audit will be completed on or before October 15th, 2022. ED or designee will review and monitor incidents each workday and will report to DOH within 1 business day of incident, and ensure the 5 day report is submitted on time.<br><br>B) With respect to what the facility will do to PREVENT the same deficiency from recurring:<br>1. ED and WD will all be in-serviced on reporting requirements and procedures in accordance with NMDOH regulations. In-service will take place on or before October 15th, 2022 and documented on an in-service sign-in sheet. | 10/15/22 |

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| A 032 | Continued From page 2 | A 032 | | |

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 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 that an Incident Report was submitted to the Licensing Authority within 24 hours or the next business day of the incident and that the investigation follow-up report was submitted to the Licensing Authority within 5 business days from the date an incident occurred.

These deficient practices could likely result in the 75 (R #s 1-75) residents identified on the census provided by the Administrator on 09/01/22, to be at risk of harm, injury, and/or death, if incidents occur, internal investigations are not completed, and there is no oversite by the Licensing Authority. The findings are:

A. Record request for documentation that the facility completed and submitted an investigation follow-up report for intake NM#48467 revealed:
1. On 05/05/22 (Thursday) the facility untimely Self-reported to the Licensing Authority the 05/03/22 (Tuesday) incident in which a female resident with a DNR (Do Not Resuscitate) order died in the facility dining room.
2. During the incident the staff thought that the

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| A 032 | Continued From page 3<br>resident was possibly choking while eating in the dining room.<br>3. Because she had a Do Not Resuscitate (DNR) order they called the Emergency Medical Services (EMS) and asked what procedures they were allowed to do during the incident.<br>4. Due to having a DNR order they were directed by EMS to only do stomach thrusts to dislodge any food that the resident was possibly choking on.<br>5. The staff did stomach thrusts on the resident until the EMS arrived and took over.<br>6. After a few minutes the resident was not breathing and no visible food had been dislodged so EMS stopped all assistive measures and pronounced the resident "dead".<br>7. The facility failed to complete and submit a follow-up complaint investigation report to the Licensing Authority within 5 business days from the date of the 05/03/22 incident.<br><br>B. On 04/19/22 at 2:36 pm, during an interview with the Administrator, she confirmed for NM #48467 that the facility failed to:<br>1. Self-report the incident within twenty-four (24) hours or by the next business day and,<br>2. Conduct and document an investigation of the incident and submit a copy of the investigation report to the licensing authority within five (5) business days. | A 032 | | |