Division of Health Improvement

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 04/28/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE PLACE AT 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 (facility self-report) completed on 04/28/15 for the New Mexico Requirements for Assisted Living Facilities for Adults, 7.8.2 NMAC. Complaint NM # 29667 was substantiated.	A 000	Scanned 05-26-15 J.D. RECEIVED MAY 20 2015 HEALTH FACILITY LICENSING & CERTIFICATION BUREAU	
A 026	7 NMAC 8.2.26 Individual Service Plan INDIVIDUAL SERVICE PLAN (ISP): An ISP shall be developed and implemented within ten (10) calendar days of admission for each resident residing in the facility. A. The ISP shall address those areas of need as identified in the resident evaluation and through staff observation. (1) The ISP shall detail the services that are provided by the facility as well as the services to be provided by other agencies. (2) The resident evaluation and the ISP shall be reviewed and if needed revised by a licensed practical nurse, registered nurse or a physician extender. (3) The ISP shall be reviewed and or revised at a minimum of every six (6) months or when there is a significant change in the resident ' s health status. B. The ISP shall include the following: (1) a description of identified needs as noted in the resident evaluation; (2) a written description of all services to be provided; (3) who will provide the services; (4) when or how often the services will be provided; (5) how the services will be provided; (6) where the services will be provided; (7) expected goals and outcomes of the services; (8) documentation of the facility ' s determination	A 026		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Irene Weatherford — TITLE: Executive Director — (X6) DATE: 5/15/15

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A 026	Continued From page 1 that it is able to meet the needs of the resident; (9) the level of assistance that the resident will require with activities of daily living and with medications; (10) a crisis prevention/intervention plan when indicated by diagnosis or behavior; and (11) current orders for all medications, including those authorized for PRN usage. [7.8.2.26 NMAC - Rp, 7.8.2.27 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: The following refers to paragraph 7.8.2.26 (3) Based on record review and interview, the facility failed to revise an individual service plan for 1 (R #1) of 4 (R #1, 2, 3, and 4) sampled residents who experienced a change of condition. This deficient practice could negatively impact resident care and possibly cause harm through lack of accurate documentation of resident condition. The findings are: A. Review of Resident #1's record revealed that she had experienced falls on 03/27/15, 03/28/15, and 03/30/15. B. On 04/28/15 at 9:30 am, during observation and interview, Resident #1 was visited in her room. She could not communicate what happened. C. On 04/28/15 at 11:00 am, during interview, Physician #1 stated that R#1's condition had deteriorated since the end of February, 2015 and that the falls can be attributed to increasing dementia and worsening of her physical condition.	A 026	Resident individual service plans will be reviewed & revised as necessary following a change in condition of the resident that results in altered care needs. Specific plans will be included to address change in ADLs, ie, transfer, escort, nutrition needs, incontinence care, etc. This will be completed by the nurse in AL immediately & on-going. Risk identification evaluation to be completed in conjunction with the ISP by nurse and alert charting to be initiated for 72 hours immediately & on-going. Staff to be trained on fall prevention and reporting change of condition.	Immediate and on-going. Immediate and on-going. 5/14/2015

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A 026	Continued From page 2 D. On 04/28/15 at 9:45 am, during interview, family member #1 stated, "The facility staff thought she had a fracture of the right hand. There was no fracture, but she did have gout. They took her to the hospital and found the T12 (compression fracture of the spine) fracture for which she underwent surgery (Kyphoplasty). In my opinion, the staff is providing good care. She has gone down hill the last 1 1/2 months. She was put on hospice yesterday because she is not eating." E. Record review of the three falls experienced by Resident #1 revealed the following: 1. The facility post-fall evaluation for Resident #1's fall on 03/27/15 documented that she suffered no injury as well as a statement from Resident #1 that she did not remember how she got on the floor. The section of the form that documented compliance with safety interventions stated that she did not use her walker. 2. The facility post-fall evaluation for Resident #1's fall on 03/28/15 documented that Resident #1 said that she fell. The form stated that Resident #1 had experienced a change of condition during the past 30 days. Her change in cognitive status was identified as a risk factor that contributed to the fall. 3. The facility post-fall investigation report for resident #1's fall on 03/30/15 documented that Resident #1 did not know what happened. Her post-fall evaluation revealed documentation of worsening dementia over the past 30 days. D. Record review of R #1's latest individual service plan, dated 01/09/15, revealed no requirements for a special falls prevention program and no evidence of an updated plan after she fell 3 times in 4 days.	A 026		

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A 026	Continued From page 3 E. On 04/28/15 at 1:30 pm, when asked why R #1's individual service plan had not been updated, the Health Services Director stated that since R #1 was awaiting hospice placement, no update had been completed.	A 026		