Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2154	A. BUILDING: _____ B. WING _____	C 02/28/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TENDER HEART ASSISTED LIVING	4308 TULANE DRIVE NE ALBUQUERQUE, NM 87107

(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 A survey was completed for NMAC 7.8.2 regulations governing Assisted Living facilities for intake #28922. The complaint was substantiated and a deficiency was cited.	A 000	7.8.2.33 Resident Rights #1 The violations identified in the official statement of deficiency will be corrected by: B.) The development and implementation of an Incident Reporting protocol checklist in the event of any falls within the facility which will include an electronic alert system. B.) Re-training of all house staff with regards to incident protocol and checklist.	
A 033	7 NMAC 8.2.33 Resident Rights RESIDENT RIGHTS: All licensed facilities shall understand, protect and respect the rights of all residents. A. Prior to admission to a facility, a resident and legal representative shall be given a written description of the legal rights of the resident, translated into another language, if necessary, to meet the resident ' s understanding. B. If the resident has no legal representative and is incapable of understanding his or her legal rights, a written copy of the resident's legal rights shall be provided to the most significant responsible party in the following order: (1) the resident's spouse; (2) significant other; (3) any of the resident's adult children; (4) the resident's parents; (5) any relative the resident has lived with for six or more months before admission; (6) a person who has been caring for, or paying benefits on behalf of the resident; (7) a placing agency; (8) resident advocate; or (9) the ombudsman. C. The resident rights shall be posted in a conspicuous public place in the facility and shall include the telephone numbers for the incident management hotline and for the state ombudsman program. D. To protect resident rights, the facility shall: (1) treat all residents with courtesy, respect, dignity and compassion;	A 033	Scanned 5/22/13 KH	

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MAY 21 2013
HEALTH FACILITY LICENSING & CERTIFICATION BUREAU

Division of Health Improvement

Tracy Myers, Compliance 5-16-13

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

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A 033	Continued From page 1 (2) not discriminate in admission or services based on gender, sexual orientation, resident's age, race, religion, physical or mental disability, or nationality; (3) provide residents written information about all services provided by the facility and their costs and give advance written notice of any changes; (4) provide residents with a safe and sanitary living environment; (5) provide humane care for all residents; (6) provide the right to privacy, including privacy during medical examinations, consultations and treatment; (7) protect the confidentiality of the resident ' s medical record; (8) protect the right to personal privacy, including privacy in personal hygiene; privacy during visits with a spouse, family member or other visitor; and privacy in the resident's own room; (9) protect the right to communicate privately and freely with any person, including private telephone conversations and private correspondence; and the right to receive visits from family, friends, lawyers, ombudsmen and community organizations; (10) prohibit the use of any and all physical and chemical restraints; (11) ensure that residents: (a) are free from physical and emotional abuse neglect and misappropriation/or exploitation; (b) are free from financial abuse and misappropriation by facility staff or management; (c) are free to participate in religious, social, community and other activities and freely associate with persons in and out of the facility; (d) are free to leave the facility and return without unreasonable restriction; (e) are given a fifteen (15) calendar day, written notice before room transfers or discharge from the facility unless there is immediate danger to	A 033	2. The facility will monitor the corrective action and ensure ongoing compliance by having the manager call the staff upon electronic alert of an incident (if manager is off site) and review the checklist with the staff for every fall that occurs within the house to ensure proper protocol is followed. Upon the same electronic alert, one of the facility owners will also review the documentation and review the incident with the manager to ensure proper protocol was followed.	

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A 033	Continued From page 2 self or others in the facility; (f) have an environment that fosters social interaction and avoids social isolation; (g) or their surrogate decision makers, are informed of and consent to the services provided by the facility; (h) have the right to voice grievances to the facility staff, public officials, the ombudsmen, any state agency, or any other person, without fear of reprisal or retaliation; (i) have the right to have their complaints addressed within fourteen (14) calendar days or sooner; (j) have the right to participate in the development of their care plan/ISP; (k) have the right to choose a doctor, pharmacist and other health care provider(s); (l) have the right to participate in medical treatment decisions and formulate advance directives such as living wills and powers of attorney; (m) have the right to keep and use personal possessions without loss or damage; (n) have the right to manage and control their personal finances; (o) have the right to freely organize and participate in a resident association that may recommend changes in the facility's policies, services and management; (p) shall not be required to work for the facility; and (q) are protected from unjustified room transfers or discharge. E. The resident's rights shall not be restricted unless this restriction is for the health and safety of the resident, agreed to by the resident or the resident ' s surrogate decision maker and outlined in the resident ' s individual service plan. [7.8.2.33 NMAC - Rp, 7.8.2.34 NMAC, 01/15/2010]	A 033	3. The checklist, training and electronic alert system will be put into place within 30 days from the date of the notification letter (June 9, 2013.)	

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A 033	Continued From page 3 This REQUIREMENT is not met as evidenced by: Based on record reviews and interviews, the facility failed to protect the resident's right to humane care by failing to summon emergency medical care immediately subsequent to a fall for one (Resident #1). This has the potential to cause widespread failure to summon medical care for accidents. The findings are: A. On 01/28/13 at 11:56 am during interview with Paramedic #1, he reported that Emergency Medical Services (EMS) was called to the facility on an emergency call on 01/13/13 at 2:30 pm. Upon arrival, resident Resident #1 was observed to have an already blackened eye and black and blue cheek with diminished mentation (diminished metal state) Paramedic #1 reports that when facility staff was interviewed, it was reported to EMS that the resident had fallen on 01/12/13 at around 10:30 pm the previous night, 16 hours previous. When EMS Paramedics inquired of staff why it had taken so long to call 911, the staff responded that "they were following protocol" and doing what Manager #1 decided to do about the situation. When EMS attempted to move Resident #1, she yelled in pain, was very stiff and it appeared that her right arm was broken. Staff also reported to EMS that they noticed diminished mental status because Resident #1 is usually able to talk to them, indicating to EMS that there may also have been a head injury of the resident. Paramedic #1 stated that the eye and arm were pretty bad, so it was a hard fall. Finally, Paramedic #1 reported that in his opinion, the incident "wasn't handled properly." That black eye was fully black, it didn't just happen when we got there. This was really way out of the ordinary	A 033		

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A 033	Continued From page 4 and it really concerned me. B. Review of facility policy for actions to be taken in case of accidents or emergencies reads: 1. Caregivers immediately summon the community RSM (manager) should a resident exhibit signs and symptoms of a medical emergency [sic] 2. The RSM makes a determination as to the severity of the situation [sic]. 3. After instruction from the RSM, the community summons emergency medical services (by calling 911), when the resident exhibits signs and symptoms of distress and/or emergency condition. Examples include, but are not limited to: [sic] fall with deformity, severe pain or head injury [sic]. 4. The RSM contacts the family as quickly as possible [sic] 5. The RSM or caregivers are not required to obtain permission from the family/responsible party before summoning emergency medical services [sic] 6. A narrative chart entry is made in the resident ' s chart regarding the circumstances which led up to the call, what care was provided by the staff, including any first aid, as well as the resident ' s response to the action [sic] 7. An incident report is completed [sic] 8. The physician or physician extender is notified [sic]. C. During interview with Manager #1, on 01/29/13 at 9:20 am, she reported that the process for handling emergencies is as follows: 1. Facility staff calls Manager 2. An internal incident report is filed 3. If there is injury, then family/responsible party is contacted 4. If it is 'really bad' (injury), 911 is called.	A 033		

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A 033	Continued From page 5 D. On 01/29/13 at 3:30 pm during interview with Caregiver #2, she reported that Caregiver #1 was working on the night shift of 01/12/13 when Resident #1 fell. Caregiver #1 further reported that she and Caregiver #3 worked the following morning. She reports that Resident #1 was functional until the afternoon when she verbalized pain. At this time, it was reported to Manager #1, who contacted the guardian and sent Resident #1 to the hospital. E. Review of incident report dated 01/12/13 at 10:15 pm revealed that Resident #1 was found in her room, subsequent to Caregiver #1 hearing a "thump." Resident #1 was found on the floor and apparently stated that " the door had hit her." It reads that Caregiver #1 "checked her to make sure she was "okay" then "helped her back to bed." Actions taken included notification of Manager #1. Report read that "[Manager #1] told me to make sure [Resident #1] was okay & to assist her with some Tylenol for the pain and she [Manager #1] will check on her in the morning." F. On 02/28/13 at 8:26 am during interview with Manager #1, she reports that per protocol, the caregiver on duty informed her of the fall of Resident #1. She went on to say that Caregiver #1 did not convey the seriousness of the fall and did not call her back with a serious change in condition, so that is why she did not go over in the middle of the night to check on Resident #1. She stated that she is ultimately responsible for making the decision to summon medical care for the residents. Manager #1 stated that she did not see the resident until the next day when the decision was made to call Emergency Services.	A 033		