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 07/28/2015

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
A 000	Initial Comments The following deficiencies were cited during a complaint investigation survey completed on 07/28/15 for the New Mexico Requirements for Assisted Living Facilities for Adults, 7.8.2.NMAC. Complaint NM #29708 was unsubstantiated.	A 000	The following is a plan of correction for Brookdale Tramway Ridge regarding The statement of deficiencies, 7/28/15. This plan of correction is not to be Construed as an admission of or Agreement with the findings and Conclusions in the Statement of Deficiencies or any related sanction Or fine. Rather, it is submitted as Confirmation of our ongoing Efforts to comply with the Statutory and regulatory requirements In this document, we have outlined Specific actions in response to The Identified mitigating factors. We Remain committed to the delivery of Quality health care services and will Continue to make changes and Improvements to satisfy that objective.	
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 incident. [7.8.2.32 NMAC - Rp, 7.8.2.32 NMAC,	A 032		

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Division of Health Improvement
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Patricia Jaris — TITLE: Executive Director — (X6) DATE: 8/27/15

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A 032	Continued From page 1 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.32 A (1) Based on record review and interview, the facility failed to comply with state of New Mexico Department of Health incident reporting requirements by not reporting Injuries of unknown source and unwitnessed falls for 4 (R #1, 2, 3, 4) of 8 sampled residents. This deficient practice increases the likelihood that residents would be subject to abuse, neglect and exploitation if the facility is not reporting and investigating incidents of unwitnessed falls and injuries of unknown injuries. Caregivers would not be identified, disciplined, or placed on the employee abuse registry to preclude them from performing similar acts in the future. The findings are: A. Record review of incident reports revealed that Resident # 1 had an unwitnessed fall on 02/12/15 with injury. The patient sustained a skin tear to right wrist. The incident report states that the resident could not remember how she fell, the resident was sent out for assessment. There was not a record found in the facilities state reporting binder that a state incident report or a 5 day investigation report being made to the State Licensing Authority complaint hotline. B. Review of a facility incident report revealed that on 05/23/15, R #2 was found in his room on the floor at his bedside. A small abrasion was noted above his left eyebrow. 911 was called. Paramedics did not take the resident to the hospital because the resident's daughter declined	A 032	Compliance Date We will address all violations by appointing Our Health and Wellness Director to review Daily incidents and report any incidents of Unknown origin or unwitnessed, also if Resident has a cognitive impairment and Not able to communicate. Executive Director Will meet daily with Health and Wellness Director to insure all events are reported Timely. This process will be reviewed Monthly in our Quality Assurance meeting For 3 months, and ongoing as needed.	8/5/15

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A 032	Continued From page 2 treatment. There was no record found in the facilities state reporting binder of a state incident report or a 5 day investigation report being made to the State Licensing Authority complaint hotline. C. Record review of incident reports revealed that R #3 suffered falls 03/21/15 and 05/01/15. The incident report for 03/21/15 stated that the resident was very weak and lost her balance. Staff heard the resident yelling and when they entered the room the resident was on the floor. There was bruising, redness, and skin tear. The incident report for 05/01/15 stated the fall was unwitnessed and that the resident had bruising, skin tear and swelling. There was no record found in the facilities state reporting binder of a state incident report or a 5 day investigation report being made to the State Licensing Authority complaint hotline. D. Record review of incident reports revealed that resident R #4 suffered a fall on 06/26/15 and received a scrape/laceration to his forehead. The incident report quotes the resident as saying "I was trying to get out of bed on my own and lost my balance." Resident Log entry on 06/26/15 noted that although the resident stated that he was trying to get into the wheelchair from the bed, but the log noted that the wheelchair was not near his bed. There was no record found in the facilities state reporting binder of a state incident report or a 5 day investigation report being made to the State Licensing Authority complaint hotline. E. On 07/28/15 at 9:45 am, during an interview with the RN, Case Manager (RNCM) #2, the incident reports for (R # 1, 2, 3, 4) were reviewed. She confirmed the incidents were not reported to the State Licensing Authority complaint hotline. When asked if these incidents of unwitnessed falls with injuries should have be reported, she confirmed that they should have	A 032	See page two for Plan of Correction	8/5/15

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A 032	Continued From page 3 been reported to the State Licensing Authority complaint hotline.	A 032		