

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  2055	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  C 08/04/2022
NAME OF PROVIDER OR SUPPLIER  BROOKDALE VALENCIA		STREET ADDRESS, CITY, STATE, ZIP CODE 300 VALENCIA DRIVE SE ALBUQUERQUE, NM 87108		
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A 000	<p>Initial Comments</p> <p>The following deficiencies were cited during a Full onsite/Complaint survey completed on 08/04/22 for the state requirements according to the 7.8.2 NMAC Regulations for Assisted Living Facilities for Adults.</p> <p>Complaint Intake ID # NM 51358 was Unsubstantiated with no deficiencies cited related to the complaint.</p> <p>Complaint Intake ID # NM 56259 was Unsubstantiated with no deficiencies cited related to the complaint.</p> <p>Complaint Intake ID # NM 59562 was Unsubstantiated with no deficiencies cited related to the complaint.</p> <p>ABBREVIATIONS:</p> <ol style="list-style-type: none"> <li>1. Resident: R</li> <li>2. Direct Care Staff: DCS</li> <li>3. Health &amp; Wellness Director: HWD</li> <li>4. Emergency Medical Services: EMS</li> <li>5. Emergency Room: ER</li> <li>6. Incident Report: IR</li> <li>7. Assisted Living Facility: ALF</li> <li>8. New Mexico: NM</li> <li>9. New Mexico Department of Health - Division of Health Improvement: NM DOH - DHI</li> <li>10. Policy and Procedure: P/P</li> <li>11. Registered Nurse: RN</li> <li>12. Licensed Practical Nurse: LPN</li> <li>13. Physicians Extender: PE</li> <li>14. Coronavirus disease: COVID-19 virus (Coronavirus is a contagious respiratory disease caused by the SARS-CoV-2 virus)</li> <li>15. Severe Acute Respiratory Syndrome Coronavirus 2: SARS-CoV-2 virus</li> </ol>	A 000	<p>The following is the Plan of Correction for <b>BROOKDALE VALENCIA</b> regarding the Statement of Deficiencies dated 8/4/2022. 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 statutory and regulatory requirements. In this document, we have outlined specific actions in response to identified issues. We have not provided a detailed response to each allegation or finding, nor have we identified mitigating factors. We remain committed to the delivery of quality health care services and will continue to make changes and improvement to satisfy that objective.</p>	

Division of Health Improvement

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S  
SIGNATURE

*M. Rusham*

TITLE

*Executive Director*

(X8) DATE

*8/21/2022*

STATE FORM

6899

D4TL11

If continuation sheet 1 of 35

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A 017	Continued From page 1	A 017		

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A 017 7 NMAC 8.2.17 Staff Training

A 017

STAFF TRAINING:

- A. Training and orientation for each new employee and volunteer that provides direct care shall include a minimum of sixteen (16) hours of supervised training prior to providing unsupervised care for residents.
- B. Documentation of orientation and subsequent trainings shall be kept in the personnel file at the facility.
- C. Training shall be provided at orientation and at least twelve (12) hours annually, the orientation, training and proof of competency shall include:
- (1) fire safety and evacuation training;
  - (2) first aid;
  - (3) safe food handling practices (for persons involved in food preparation), to include:
    - (a) instructions in proper storage;
    - (b) preparation and serving of food;
    - (c) safety in food handling;
    - (d) appropriate personal hygiene; and
    - (e) infectious and communicable disease control;
  - (4) confidentiality of records and resident information;
  - (5) infection control;
  - (6) resident rights;
  - (7) reporting requirements for abuse, neglect or exploitation in accordance with 7.1.13 NMAC;
  - (8) smoking policy for staff, residents and visitors;
  - (9) methods to provide quality resident care;
  - (10) emergency procedures;
  - (11) medication assistance, including the certificate of training for staff that assist with medication delivery; and
  - (12) the proper way to implement a resident ISP for staff that assist with ISPs.
- D. If a facility provides transportation to residents, employees of the facility who drive vehicles and

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A 017	<p>Continued From page 2</p> <p>transport residents shall have training in transportation safety for the elderly and disabled, including safe vehicle operation. [7.8.2.17 NMAC - Rp, 7.8.2.17 NMAC, 01/15/2010]</p> <p>This REQUIREMENT is not met as evidenced by: 7.8.2.17 A. B.</p> <p>Based on record review and interview the facility failed to ensure that there was documentation kept in the personnel files at the facility that Direct Care Staff (DCS) received sixteen (16) hours of supervised training prior to providing unsupervised care.</p> <p>This deficient practice could likely result in the 48 (R #s 1-48) residents listed on the resident census, provided by the Executive Director on 07/18/22, to be at risk of harm if they are receiving care and services by DCS who have not received the required trainings. The findings are:</p> <p>A. Record review of DCS #s 1's (hire date 12/02/15) training files revealed no documentation of completing the sixteen (16) hours of supervised training, prior to providing unsupervised care for residents.</p> <p>B. Record review of DCS #s 2's (hire date 06/25/05) training files revealed no documentation of completing the sixteen (16) hours of supervised training, prior to providing unsupervised care for residents.</p> <p>C. Record review of DCS #s 3's (hire date 10/11/16) training files revealed no documentation of completing the sixteen (16)</p>	A 017	<ol style="list-style-type: none"> <li>1) Documentation of completing the 16 hours of supervised training prior to unsupervised care was not evidenced in the reviewed personnel files. DCS #4 has supervised training noted on the staff schedule and timekeeping system.</li> <li>2) The Business Office Manager/designee will audit Direct Care Staff personnel files to check for required documentation. The community will utilize a Brookdale orientation checklist and validate documentation in direct care staff personnel files for new hires.</li> <li>3) The nurse/designee is responsible for compliance with this plan.</li> <li>4) To assist with ongoing compliance, the Executive Director/designee will audit 2 new hires per month for 6 months.</li> <li>5) Completion Date: August 31, 2022</li> </ol>	

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A 017	Continued From page 3  hours of supervised training, prior to providing unsupervised care for residents.  D. Record review of DCS #s 4's (hire date 06/14/22) training files revealed no documentation of completing the sixteen (16) hours of supervised training, prior to providing unsupervised care for residents.  E. On 07/19/22 at 11:37 am, during an interview with the Executive Director, she stated that there is no documentation of DCS #s 1-4 completing the required 16-hours of supervised training.	A 017		
A 018	7 NMAC 8.2.18 Policies  POLICIES: The facility shall have and implement written personnel policies for the following: A. staff, private duty attendant and volunteer qualifications; B. staff, private duty attendant and volunteer conduct; C. staff, private duty attendant and volunteer training policies; D. staff and private duty attendant and volunteer criminal history screening; E. emergency procedures; F. medication administration; G. the retention and maintenance of current and past personnel records; and H. facilities shall maintain records and files that reflect compliance with NM and federal employment rules. [7.8.2.18 NMAC - Rp, 7.8.2.17 NMAC, 01/15/2010]	A 018		

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A 018	<p>Continued From page 4</p> <p>This REQUIREMENT is not met as evidenced by: 7.8.2.18 A. C.</p> <p>Based on record review and interview the facility failed to ensure that there are written personnel policies established and implemented which includes how the facility intends to comply with all requirements of these regulations.</p> <p>This deficient practice could likely result in the 48 (R #s 1-48) residents listed on the resident census, provided by the Executive Director on 07/18/22, to be at risk for harm, illness, or injury if the staff have lack of knowledge and/or training regarding the facility's guidelines, procedures, rules and regulations.</p> <p>The findings are:</p> <p>A. Record review of the facility's Policy and Procedure (P/P) Manual (no review date), revealed at a minimum the following P/P were not identified for the following:</p> <ol style="list-style-type: none"> <li>1. Qualifications for staff, private duty attendants and volunteers;</li> <li>2. Training policies for staff, private duty attendants and volunteers.</li> </ol> <p>B. On 07/19/22 at 10:54 am, during an interview with the facility's Executive Director, she confirmed that the facility does not have Policies for Qualifications and Training as indicated above.</p>	A 018	<ol style="list-style-type: none"> <li>1) Qualifications for staff are currently identified on the Job Description. Training for new associates includes Learning Module System Relias/iLearn and Associate Foundations schedule. The Policy &amp; Procedure Manual identifies CNO review date of October 1, 2021.</li> <li>2) The Community leadership will submit a request for development of a policy for staff qualifications and training following the established Brookdale policy on Development and Revision of Policies/Documents &amp; Approval.</li> <li>3) Executive Director/Health &amp; Wellness Director/Business Office Manager/designees are responsible for this plan.</li> <li>4) To assist with compliance, the Business Office Manager/designee will complete an audit of personnel files for signed job descriptions and training documentation.</li> <li>5) Completion Date: August 31, 2022</li> </ol>	

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A 020	7 NMAC 8.2.20 Admissions and Discharge  ADMISSIONS AND DISCHARGE: The facility shall complete an admission agreement for each	A 020	
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A 020	<p>Continued From page 5</p> <p>resident. The administrator of the facility or a designee responsible for admission decisions shall meet with the resident or the resident ' s surrogate decision maker prior to admission. No resident shall be admitted who is below the age of eighteen (18) or for whom the facility is unable to provide appropriate care.</p> <p>A. Admission agreement. The admission agreement shall include the following information:</p> <p>(1) the parties to the agreement;</p> <p>(2) the program narrative;</p> <p>(3) the facility's rules;</p> <p>(4) the cost of services and the method of payment;</p> <p>(5) the refund provision in case of death, transfer, voluntary or involuntary discharge;</p> <p>(6) information to formulate advance directives;(7) a written description of the legal rights of the residents translated into another language, if necessary;</p> <p>(8) the facility's staffing ratio;</p> <p>(9) written authorization for staff to assist with medications;</p> <p>(10) notification of rights and responsibilities pursuant to the Incident Reporting Intake, Processing and Training Requirements, 7.1.13 NMAC;</p> <p>(11) the facility ' s bed hold policy; and</p> <p>(12) the admission agreement may be terminated if an appropriate placement is found for the resident, under the following circumstances: (a) there shall be a fifteen (15) day written notice of termination given to the resident or his or her surrogate decision maker, unless the resident requests the termination;</p> <p>(b) the resident has failed to pay for a stay at the facility as defined in the admission agreement;</p> <p>(c) the facility ceases to operate or is no longer able to provide services to the resident;</p>	A 020		
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A 020	<p>Continued From page 6</p> <p>(d) the resident ' s health has improved sufficiently and therefore no longer requires the services of the facility;</p> <p>(e) termination without prior notice is permitted in emergency situations for the following reasons: (i) the transfer or discharge is necessary for the resident's safety and welfare;</p> <p>(ii) the resident's needs cannot safely be met in the facility; or</p> <p>(iii) the safety and health of other residents and staff in the facility are endangered;</p> <p>(13) the facility shall provide a thirty (30) day written notice to residents regarding any changes in the cost or the material services provided; a new or amended admission agreement must be executed whenever services, costs or other material terms are changed; and</p> <p>(14) facilities representing their services as " specialized " must disclose evidence of staff specialty training to prospective residents.</p> <p>B. Restrictions in admission. The facility shall not admit or retain individuals that require twenty-four (24) hour continuous nursing care, refer to Subsection U of 7.8.2.7 NMAC Definitions. This rule does not apply to hospice residents who have elected to receive the hospice benefit. Conditions or circumstances that usually require continuous nursing care may include but are not limited to the following:</p> <p>(1) ventilator dependency;</p> <p>(2) pressure sores and decubitus ulcers (stage III or IV);</p> <p>(3) intravenous therapy or injections;</p> <p>(4) any condition requiring either physical or chemical restraints; (5) nasogastric tubes;</p> <p>(6) tracheostomy care;</p> <p>(7) residents that present an imminent physical threat or danger to self or others;</p>	A 020	
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<p>A 020</p>	<p>Continued From page 7</p> <p>(8) residents whose psychological or physical condition has declined and placement in the current facility is no longer appropriate as determined by the PCP;</p> <p>(9) residents with a diagnosis that requires isolation techniques;</p> <p>(10) residents that require the use of a Hoyer lift; and</p> <p>(11) ostomy (unless resident is able to provide self care).</p> <p>C. Exceptions to admission, readmission and retention. If a resident requires a greater degree of care than the facility would normally provide or is permitted to provide and the resident wishes to be re-admitted or remain in the facility and the facility wishes to re-admit or retain the resident. The facility shall comply with the following requirements.</p> <p>(1) Convene a team, comprised of:</p> <p>(a) the facility administrator and a facility health care professional if desired;</p> <p>(b) the resident or resident 's surrogate decision maker; and</p> <p>(c) the hospice or home health clinician.</p> <p>(2) The team shall jointly determine if the resident should be admitted, readmitted or allowed to remain in the facility. Team approval shall be in writing, signed and dated by all team members and the approval shall be maintained in the resident's record and shall:</p> <p>(a) be based upon an individual service plan (ISP) which identifies the resident's specific needs and addresses the manner that such needs will be met;</p> <p>(b) ensure that if the facility is licensed for more than eight (8) residents and does not have complete fire sprinkler coverage, the facility shall maintain an evacuation rating score of prompt as determined by the fire safety equivalency system</p>	<p>A 020</p>		
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A 020	<p>Continued From page 8</p> <p>(FSES);</p> <p>(c) evaluate and outline how meeting the specific needs of the resident will impact the staff and the other residents; and</p> <p>(d) include an independent advocate such as a certified ombudsman if requested by the resident, the family or the facility.</p> <p>(3) The team recommendation shall be maintained on site in the resident ' s file.</p> <p>(4) When a resident is discharged, the facility shall record where the resident was discharged to and what medications were released with the resident.</p> <p>D. Coordination of care.</p> <p>(1) Assisted living facilities shall have evidence of care coordination on an ISP for all services that are provided in the facility by an outside health care provider, such as hospice or home health providers.</p> <p>(2) Residents shall be given a list of providers, including hospice and home health if applicable, and have the right to choose their provider. If applicable, the referring party shall disclose any ownership interest in a recommended or listed provider.</p> <p>[7.8.2.20 NMAC - Rp, 7.8.2.19 NMAC &amp; 7.8.2.20 NMAC, 01/15/2010]</p> <p>This REQUIREMENT is not met as evidenced by: 7.8.2.20 A (5)</p> <p>Refer to Senate Bill (SB) 0335 - 2013</p> <p>AN ACT RELATING TO HEALTH CARE; REQUIRING CONTRACTS FOR ASSISTED LIVING FACILITIES TO CONTAIN A REFUND POLICY UPON TERMINATION OF A</p>	A 020	
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A 020	<p>Continued From page 9</p> <p><b>CONTRACT DUE TO THE DEATH OF THE RESIDENT; PROVIDING FOR STORAGE OF A RESIDENT'S BELONGINGS; DECLARING AN EMERGENCY. BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF NEW MEXICO:</b></p> <p><b>SECTION 1.</b> A new section of the Public Health Act is enacted to read:  <b>"ASSISTED LIVING FACILITIES CONTRACTS--LIMIT ON CHARGES AFTER RESIDENT DEATH.--</b></p> <p>A. The contract for each resident of an assisted living facility shall include a refund policy to be implemented at the time of a resident's death. The refund policy shall provide that the resident's estate or responsible party is entitled to a prorated refund based on the calculated daily rate for any unused portion of payment beyond the termination date after all charges have been paid to the licensee. For the purpose of this section, the termination date shall be the date the unit is vacated by the resident due to the resident's death and cleared of all personal belongings.</p> <p>B. If a resident's belongings are not removed within one week of the resident's death and the amount of belongings does not preclude renting the unit, the facility may clear the unit and charge the resident's estate for moving and storing the items at a rate equal to the actual cost to the facility, not to exceed ten percent of the regular rate for the unit; provided that the responsible party for the resident is given notice at least one week before the resident's belongings are removed. If the resident's belongings are not claimed within forty-five days after notification, the facility may dispose of them.</p> <p>C. :For the purposes of this section, "assisted living facility" means a facility required</p>	A 020	
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<p>A 020</p>	<p>Continued From page 10</p> <p>to be licensed as an assisted living facility for adults by the department of health." SECTION 2. EMERGENCY.--It is necessary for the public peace, health and safety that this act take effect immediately.</p> <p>Based on record review and interview the facility failed to ensure for 2 (R #s 2 &amp; 5) of 6 (R #s 1-6) residents whose Admission/Discharge Agreements were reviewed for compliance, included a complete refund provision in case of death that is in compliance with 7 NMAC 8.2.20 Regulations for Assisted Living Facilities and a Senate Bill (SB) 0335 - 2013.</p> <p>This deficient practice could likely result in the residents Power of Attorney (POA) to be at risk of not receiving monies owed or aware of additional charges that may be incurred upon the death of a resident</p> <p>The findings are:</p> <p>A. Record review of R #2's Admission/Discharge agreement (dated [REDACTED] '22) revealed the Admission/Discharge Agreement did not include a complete refund provision in case of death.</p> <p>B. Record review of R #5's Admission/Discharge agreement (dated [REDACTED] '22), revealed the Admission/Discharge Agreement did not include a complete refund provision in case of death.</p> <p>C. On 0/19/22 at 9:30 am, during an interview with the Executive Director, she confirmed R #s 2 &amp; 5 Admission/Discharge Agreements did not include a complete refund provision in case of death.</p>	<p>A 020</p>	<ol style="list-style-type: none"> <li>1) District Director validated that Residents #2 &amp; # 5 have a refund provision clause in the signed Residency Agreement on file. (page 5, III. B. 2)</li> <li>2) The Community will maintain the practice utilizing Brookdale Residency Agreements.</li> <li>3) The Executive Director/designee is responsible for this plan.</li> <li>4) The Community will validate signed Residency Agreement for each new Move In, auditing new Move In files monthly for 3 months.</li> <li>5) Completion Date: August 4, 2022.</li> </ol>	
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<p>STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION</p>	<p>(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  2055</p>	<p>(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____</p>	<p>(X3) DATE SURVEY COMPLETED  C 08/04/2022</p>	
<p>NAME OF PROVIDER OR SUPPLIER  BROOKDALE VALENCIA</p>		<p>STREET ADDRESS, CITY, STATE, ZIP CODE 300 VALENCIA DRIVE SE ALBUQUERQUE, NM 87108</p>		
<p>(X4) ID PREFIX TAG</p>	<p>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</p>	<p>ID PREFIX TAG</p>	<p>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</p>	<p>(X5) COMPLETE DATE</p>

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A 021	Continued From page 11	A 021		
A 021	<p>7 NMAC 8.2.21 Resident Records</p> <p><b>RESIDENT RECORDS:</b></p> <p>A. Record contents. A record for each resident shall be maintained in accordance with the specific requirements of this section. Entries in each resident's record shall be legible, dated and authenticated by the signature of the person making the entry. Resident records shall be readily available on site and organized utilizing a table of contents. Each resident record shall include:</p> <p>(1) the admission agreement records, as set forth in 7.8.2.20 NMAC;</p> <p>(2) the resident evaluation form, that is to be completed within fifteen (15) days prior to admission and updated at a minimum of every six (6) months;</p> <p>(3) the current ISP, that is to be completed within ten (10) calendar days of admission and updated at a minimum of every six (6) months;</p> <p>(4) the physical examination report; the physical examination report shall have been completed within the past six (6) months, by a primary care physician, a nurse practitioner or a physician ' s assistant and shall be on file in the resident ' s record within ten (10) days of admission;</p> <p>(5) personal and demographic information for the resident, to include:</p> <p>(a) current names, addresses, relationship and phone numbers of family members, or surrogate decision makers updated as necessary;</p> <p>(b) resident's name;</p> <p>(c) age;</p> <p>(d) recent photograph;</p> <p>(e) marital status;</p> <p>(f) date of birth;</p> <p>(g) sex;</p> <p>(h) address prior to admission;</p>	A 021		

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A 021	Continued From page 12 (i) religion (optional); (j) personal physician; (k) dentist; (l) social history; (m) surrogate decision maker or other emergency contact person; (n) language spoken and understood; (o) legal documentation relevant to commitment or guardianship status; (p) current medications list; and (q) required diet; (6) unless included in the admission agreement, a separate written agreement between the facility and the resident relating to the resident's funds, in accordance with the facility's policy and procedures; (7) entries by direct care staff, appropriate health care professionals and others authorized to care for the resident; entries shall be dated and signed by the person making the entry and shall include significant information related to the ISP; (8) entries that provide a written account of all accidents, injuries, illnesses, medical and dental appointments, any problems or improvements observed in the resident, any condition that would indicate a need for alternative placement or medical attention and entries reflecting appropriate follow-up; the maintenance of such written documentation in the resident record may be by copy of an incident or accident report, if the original incident or accident report is maintained elsewhere by the facility; (9) the medication assistance record (MAR); the MAR is the document that details the resident's medication; the MAR shall include all of the information pursuant to Subsection G of 7.8.2.35 NMAC of this rule; (10) progress notes completed by any contract agency (e.g., hospice, home health); the progress	A 021		
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A 021	<p>Continued From page 13</p> <p>notes shall include the date, time and type of health services provided;</p> <p>(11) copies of all completed and signed transfer forms from the accepting facility when a resident is transferred to a hospital or another health care facility and when the resident is transferred back to the facility; and</p> <p>(12) upon the death or transfer of a resident, documentation of the disposition of the resident's personal effects and money or valuables that are deposited with the assisted living facility. B. Resident records maintenance.</p> <p>(1) Current resident records shall be maintained on-site and stored in an organized, accessible and permanent manner.</p> <p>(2) The facility shall establish a policy to maintain and ensure the confidentiality of resident records, including the authorized release of information from the resident records.</p> <p>(3) Non-current resident records shall be maintained by the facility against loss, destruction and unauthorized use for a period of not less than five (5) years from the date of discharge and readily available within twenty-four (24) hours of request.</p> <p>(4) There shall be a policy and procedure in place for record retention in the event of facility closure. (5) Failure to follow facility policies is grounds for sanctions.</p> <p>[7.8.2.21 NMAC - Rp, 7.8.2.22 NMAC, 01/15/2010]</p> <p>This REQUIREMENT is not met as evidenced by: 7.8.2.21 A. (2)</p> <p>Based on record review and interview the facility failed to ensure for 1 (R #s 1) of 6 (R #s 1-6)</p>	A 021	
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<p>A 021</p>	<p>Continued From page 14</p> <p>residents whose facility record was reviewed for compliance had an initial Evaluation which was completed within fifteen (15) days prior to admission.</p> <p>This deficient practice could likely affect the health, safety, and welfare of residents if the initial evaluation was not completed prior to admission to determine the baseline level of assistance that is needed and if the level of services required by the resident can be met by the facility.</p> <p>The findings are:</p> <p>A. Record review of R #1's resident file revealed (Admission date [REDACTED] 14) no documentary evidence that an initial evaluation was completed within 15 days prior to admission.</p> <p>B. On 07/19/22 at 12:58 pm, during an interview with the facility's Health &amp; Wellness Director, she confirmed R #1's initial Evaluation was not available in the residents record for review. The Health &amp; Wellness Director indicated the resident was admitted prior to her working at the facility.</p>	<p>A 021</p>	<ol style="list-style-type: none"> <li>1) Resident #1 no longer resides in the community</li> <li>2) The community/district clinical team will audit current resident charts for initial evaluations completed within 15 days prior to admission.</li> <li>3) Health &amp; Wellness Director is responsible for this plan.</li> <li>4) To assist with ongoing compliance, the Area Nurse Manager/designee will audit a minimum of 6 resident records at the next clinical site visit.</li> <li>5) Completion date: September 30, 2022</li> </ol>	
<p>A 025</p>	<p>7 NMAC 8.2.25 Resident Evaluation</p> <p><b>RESIDENT EVALUATION:</b></p> <p>A. A resident evaluation shall be completed by an appropriate staff member within fifteen (15) days prior to admission to determine the level of assistance that is needed and if the level of services required by the resident can be met by the facility.</p> <p>B. The initial resident evaluation shall establish a baseline in the resident 's functional status and thereafter assist with identifying resident changes. The resident evaluation shall be</p>	<p>A 025</p>		

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A 025	<p>Continued From page 15</p> <p>reviewed and updated at a minimum of every six (6) months or when there is a significant change in the resident ' s health status.</p> <p>C. The resident ' s evaluation shall be documented on a resident evaluation form and at a minimum include the following abilities, behaviors or status:</p> <ol style="list-style-type: none"> <li>(1) activities of daily living;</li> <li>(2) cognitive abilities; reasoning and perception; the ability to articulate thoughts, memory function or impairment, etc;</li> <li>(3) communication and hearing; ability to communicate needs and understand instructions, etc;</li> <li>(4) vision;</li> <li>(5) physical functioning and skeletal problems;</li> <li>(6) incontinence of bowel/bladder;</li> <li>(7) psychosocial well-being;</li> <li>(8) mood and behavior;</li> <li>(9) activity interests;</li> <li>(10) diagnoses;</li> <li>(11) health conditions;</li> <li>(12) nutritional status;</li> <li>(13) oral or dental status;</li> <li>(14) skin conditions;</li> <li>(15) medication use and level of assistance needed with medications;</li> <li>(16) special treatments and procedures or special medical needs such as hospice; and</li> <li>(17) safety needs/high risk behaviors; history of falls agitation, wandering, fire safety issues, etc.</li> </ol> <p>D. The resident evaluation shall include a history and physical examination and an evaluation report by a physician or a physician extender within six (6) months of admission. A resident shall have a medical evaluation by a physician or a physician extender at least annually.</p> <p>E. The resident evaluation shall be reviewed and if needed revised by a licensed practical nurse,</p>	A 025		

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A 025	<p>Continued From page 16</p> <p>registered nurse or physician extender at the time the individual service plan is reviewed, at a minimum of every six (6) months or when a significant change in health status occurs. [7.8.2.25 NMAC - Rp, 7.8.2.25 NMAC, 01/15/2010]</p> <p>This REQUIREMENT is not met as evidenced by: 7.8.2.25 E.</p> <p>Based on record review and interview the facility failed to ensure for 5 (R #s 2, 3, 4, 5 and 6) of 6 (R #s 1-6) residents whose facility record were reviewed for compliance to ensure that their initial evaluations were reviewed and if needed revised by a Licensed Practical Nurse (LPN), Registered Nurse (RN), or a Physician Extender.</p> <p>This deficient practice could likely affect the health, safety, and welfare of residents if their initial evaluation was not reviewed by licensed personnel (LPN or RN) or a Physician Extender to ensure that the level of assistance that a resident will need was:</p> <ol style="list-style-type: none"> <li>1. The appropriate level of assistance based on the resident's abilities and behaviors and health status.</li> <li>2. That Direct Care Staff (DCS) are knowledgeable and providing the resident with the level of assistance that is required according to the evaluation.</li> </ol> <p>The findings are:</p> <p>A. Record review of R #2's Personal Service</p>	A 025		

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A 025	Continued From page 17 Assessment dated 03/16/22, had no documentary evidence that the initial evaluation was reviewed by a LPN, RN or a Physician Extender.  B. Record review of R #3's Personal Service Assessment dated 01/21/22, had no documentary evidence that the initial evaluation was reviewed by a LPN, RN or a Physician Extender.  C. Record review of R #4's Personal Service Assessment dated 02/23/21, had no documentary evidence that the initial evaluation was reviewed by a LPN, RN or a Physician Extender.  D. Record review of R #5's Personal Service Assessment dated 02/17/22, had no documentary evidence that the initial evaluation was reviewed by a LPN, RN or a Physician Extender.  E. Record review of R #6's Personal Service Assessment dated 02/17/22, had no documentary evidence that the initial evaluation was reviewed by a LPN, RN or a Physician Extender.  F. On 07/19/22 at 2:20 pm, during an interview with the facility's Health & Wellness Director, she confirmed the facility's "Personal Service Assessment" is considered the facility's "Initial Evaluation" form. The HWD confirmed that the above resident's initial evaluations do not have documentary evidence that the evaluations were reviewed by either a LPN, RN, or a Physician Extender.	A 025	1) Initial evaluations on Residents #s 2, 3, 4, all performed by LVN or RN will be signed (documentary evidence of review) by an LVN, RN or Physician Extender and maintained in the Resident Record. Residents #5 & 6 no longer reside in the community. 2) The community/district clinical team will audit current resident charts for initial evaluation signature as documentary evidence of review. 3) Health & Wellness Director is responsible for this plan. 4) To assist with ongoing compliance, the Area Nurse Manager/designee will audit a minimum of 6 resident records at the next clinical site visit. 5) Completion date: September 30, 2022	
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.	A 032		

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A 032	Continued From page 18  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, 01/15/2010]  This REQUIREMENT is not met as evidenced by: REPORTING OF INCIDENTS 7.8.2.32 A. (1) - (2), B. (1) - (3)  7.1.13 INCIDENT REPORTING, INTAKE, PROCESSING AND TRAINING REQUIREMENTS	A 032		

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A 032	<p>Continued From page 19</p> <p>Refer to 7.1.13.7 W, 8 B. (2), 10 C.</p> <p>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.</p> <p>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 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.</p> <p>C. All licensed health care facilities shall conduct a complete investigation and report the actions taken and conclusions reached by the facility within five (5) days of discovery of the incident. [7.1.13.10 NMAC - Rp, 7.1.13.11 NMAC. 7/1/14]</p> <p>Based on record review and interview, the facility</p>	A 032		

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A 032	<p>Continued From page 20</p> <p>failed to ensure for 2 (R #s 7 &amp; 8) of 24 (R #s 1 - 24) residents whose Internal Incident Reports (IR) out of forty-six (46) of the facility's Internal IRs were reviewed for compliance, that any incident of possible abuse, neglect, exploitation, injuries of unknown origin and other events including but not limited to falls which cause injury, which has or could threaten the health, safety, or welfare of the clients:</p> <ol style="list-style-type: none"> <li>1. Were reported to the Licensing Authority within 24 hours or the next business day if it is a weekend or a holiday.</li> <li>2. The facility conducted and documented the investigation of all incidents and within five (5) business days.</li> </ol> <p>This deficient practice could likely result in the residents to be at risk of harm, injury, and/or death, due to the facility failing to report any "Reportable incident" to the Licensing Authority for oversight.</p> <p>The findings are:</p> <p>A. Record review of R #7's Internal Incident Report (IR) dated 05/18/22, revealed a witnessed incident in which the resident was walking down the hallway on the first floor and fell <b>hitting her head</b> on the handrail. The resident was assessed for injuries by the facility nurse and "noted <b>redness on head</b>" and EMS was called and the resident was transported to a local hospital for further evaluation. No documentary evidence that the facility reported this incident to the Licensing Authority within 24 hours or the next business day if a holiday or weekend and that an internal investigation was conducted within 5 days.</p> <p>B. Record review of R #8's Internal Incident Report (IR) dated 03/30/22, revealed an</p>	A 032	<ol style="list-style-type: none"> <li>1) Community leadership has been re-inserviced on the regulations for Reportable Events in the NMAL Regulations 7.1.13</li> <li>2) The community team will follow the Brookdale policy and NM State Regulations for reportable events.</li> <li>3) Executive Director/Health &amp; Wellness Director/designee are responsible for this plan.</li> <li>4) To assist with compliance, the Executive Director/Health &amp; Wellness Director/designee will review internal incident report logs weekly for 1 month then monthly for 2 additional months.</li> <li>5) Completion Date: August 21, 2022</li> </ol>	

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A 032	<p>Continued From page 21</p> <p>unwitnessed incident in which the facility nurse heard someone yelling "help" "help" and upon the nurse entering the resident's room noted the resident on the floor in the bathroom. The resident was assessed for injuries by the facility nurse with no visible injuries noted or voiced. The resident's vital signs and Blood Sugar were taken. Three empty boxes of Benadryl were noted on a side table in the room and 911 was called. The resident was sent to a local hospital for further psych evaluation. No documentary evidence that the facility reported this incident to the Licensing Authority within 24 hours or the next business day if a holiday or weekend and that an internal investigation was conducted within 5 days.</p> <p>C. On 07/19/22 at 2:32 pm, during an interview with the facility's Executive Director, she confirmed that the two facility's Internal Incident Reports indicated above were not reported to the Licensing Authority within 24 hours or the next business day and the facility did not conduct and document the investigation of the above incidents within five (5) business days.</p>	A 032		
A 033	<p>7 NMAC 8.2.33 Resident Rights</p> <p>RESIDENT RIGHTS: All licensed facilities shall understand, protect and respect the rights of all residents.</p> <p>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.</p> <p>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</p>	A 033		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____	(X3) DATE SURVEY COMPLETED
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Division of Health Improvement

	2055	B. WING	C 08/04/2022
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NAME OF PROVIDER OR SUPPLIER  <b>BROOKDALE VALENCIA</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>300 VALENCIA DRIVE SE ALBUQUERQUE, NM 87108</b>
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A 033	<p>Continued From page 22</p> <p>responsible party in the following order:</p> <ol style="list-style-type: none"> <li>(1) the resident's spouse;</li> <li>(2) significant other;</li> <li>(3) any of the resident's adult children;</li> <li>(4) the resident's parents;</li> <li>(5) any relative the resident has lived with for six or more months before admission;</li> <li>(6) a person who has been caring for, or paying benefits on behalf of the resident;</li> <li>(7) a placing agency;</li> <li>(8) resident advocate; or</li> <li>(9) the ombudsman.</li> </ol> <p>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.</p> <p>D. To protect resident rights, the facility shall:</p> <ol style="list-style-type: none"> <li>(1) treat all residents with courtesy, respect, dignity and compassion;</li> <li>(2) not discriminate in admission or services based on gender, sexual orientation, resident's age, race, religion, physical or mental disability, or nationality;</li> <li>(3) provide residents written information about all services provided by the facility and their costs and give advance written notice of any changes;</li> <li>(4) provide residents with a safe and sanitary living environment;</li> <li>(5) provide humane care for all residents;</li> <li>(6) provide the right to privacy, including privacy during medical examinations, consultations and treatment;</li> <li>(7) protect the confidentiality of the resident's medical record;</li> <li>(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;</li> </ol>	A 033		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____	(X3) DATE SURVEY COMPLETED
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	2055	B. WING	C 08/04/2022
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NAME OF PROVIDER OR SUPPLIER  <b>BROOKDALE VALENCIA</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>300 VALENCIA DRIVE SE ALBUQUERQUE, NM 87108</b>
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A 033	<p>Continued From page 23</p> <p>(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;</p> <p>(10) prohibit the use of any and all physical and chemical restraints;</p> <p>(11) ensure that residents:</p> <p>(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;</p> <p>(c) are free to participate in religious, social, community and other activities and freely associate with persons in and out of the facility;</p> <p>(d) are free to leave the facility and return without unreasonable restriction;</p> <p>(e) are given a fifteen (15) calendar day, written notice before room transfers or discharge from the facility unless there is immediate danger to self or others in the facility;</p> <p>(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;</p> <p>(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;</p> <p>(i) have the right to have their complaints addressed within fourteen (14) calendar days or sooner;</p> <p>(j) have the right to participate in the development of their care plan/ISP;</p> <p>(k) have the right to choose a doctor, pharmacist and other health care provider(s);</p> <p>(l) have the right to participate in medical</p>	A 033		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____	(X3) DATE SURVEY COMPLETED
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	2055	B. WING	C 08/04/2022
NAME OF PROVIDER OR SUPPLIER  <b>BROOKDALE VALENCIA</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>300 VALENCIA DRIVE SE ALBUQUERQUE, NM 87108</b>	
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A 033	<p>Continued From page 24</p> <p>treatment decisions and formulate advance directives such as living wills and powers of attorney;</p> <p>(m) have the right to keep and use personal possessions without loss or damage;</p> <p>(n) have the right to manage and control their personal finances;</p> <p>(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> <p>(p) shall not be required to work for the facility; and</p> <p>(q) are protected from unjustified room transfers or discharge.</p> <p>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]</p> <p>This REQUIREMENT is not met as evidenced by: 7.8.2.33 C</p> <p>Based on observation and interview the facility failed to ensure that the Resident Rights poster was posted in the facility's common area.</p> <p>This deficient practice could likely result in the 48 (R #s 1-48) residents listed on the census provided by the Executive Director on 07/18/22, to be at risk of not knowing what their rights are or who to contact for assistance if proper contact information is not readily available.</p>	A 033	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____	(X3) DATE SURVEY COMPLETED
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2055		B. WING		C 08/04/2022	
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A 033	<p>Continued From page 25</p> <p>The findings are:</p> <p>A. On 07/18/22 at 1:25 pm, during observation of the facility's common area, the Resident Rights poster was not visibly posted.</p> <p>B. On 07/19/22 at 8:35 am, during an interview with the Executive Director, she confirmed that the facility did not have a Resident Rights poster, but she did request one.</p>	A 033	<ol style="list-style-type: none"> <li>1) Resident rights poster has been requested from NM Ombudsman and will be posted in common area upon receipt.</li> <li>2) The Executive Director/designee will note the posting on community rounds.</li> <li>3) The Executive Director is responsible for this plan.</li> <li>4) To assist with compliance, the leadership team will round in common areas on a weekly basis for a period of one month, then once monthly for a period of 3 months.</li> <li>5) Completion Date: August 31, 2022</li> </ol>		

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A 034	<p><b>7 NMAC 8.2.34 Custodial Drug Permits</b></p> <p><b>CUSTODIAL DRUG PERMITS:</b> A facility with two (2) or more residents that is licensed pursuant to this rule and that assists with self-administration or safeguards medications for residents shall have a current custodial drug permit issued by the state board of pharmacy.</p> <p><b>A. Procurement, labeling and storage.</b> The facility shall provide assistance to the resident in obtaining the necessary medications, treatment and medical supplies as identified in the ISP. The facility shall procure, label and store medications for residents who require assistance with self-administration of medication in compliance with state and federal laws.</p> <p>(1) All medications, including non-prescription drugs, shall be stored in a locked compartment or in a locked room, as approved by the board of pharmacy and the key shall be in the care of the administrator or designee.</p> <p>(2) Internal medication shall be kept separate from external medications. Drugs to be taken by mouth shall be separated from all other delivery forms.</p> <p>(3) A separate, locked refrigerator shall be provided by the facility for medications. The refrigerator temperature shall be kept in</p>	A 034	
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  2055	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  C 08/04/2022
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			(X5) COMPLETE DATE

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<p>A 034</p>	<p>Continued From page 26</p> <p>compliance with the state board of pharmacy requirements for medications.</p> <p>(4) All medications, including non-prescription medications, shall be stored in separate compartments for each resident and all medications shall be labeled with the resident's name.</p> <p>(5) A resident may be permitted to keep his or her own medication in a locked compartment in his or her room for self-administration, if the physician's order deems it appropriate.</p> <p>(6) The facility shall not require the residents to purchase medications from any particular pharmacy.</p> <p>(7) Medical gases (oxygen) and equipment used for the administration of inhalation therapy and for resuscitative purposes shall comply with the national fire protection association (NFPA) 99. (8) A proof of use record shall be maintained separately for each schedule II through IV drug (controlled substances). The proof of use sheet shall document:</p> <p>(a) the type and strength of the schedule II through IV drugs;</p> <p>(b) the date and time staff assisted with self-administration; (c) the resident ' s name;</p> <p>(d) the prescriber ' s name;</p> <p>(e) the dose;</p> <p>(f) the signature of the person assisting with delivery of the medication; and</p> <p>(g) the balance of medication remaining.</p> <p>(9) Any remaining medication discontinued by a physician ' s order, or upon discharge or death of the resident shall be inventoried and moved to a separate locked storage container. Such discontinued medications shall be destroyed upon the next quarterly visit by the consulting pharmacist in accordance with 16.19.11.10</p>	<p>A 034</p>	
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<p>STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION</p>	<p>(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:</p> <p>2055</p>	<p>(X2) MULTIPLE CONSTRUCTION</p> <p>A. BUILDING: _____</p> <p>B. WING: _____</p>	<p>(X3) DATE SURVEY COMPLETED</p> <p>C 08/04/2022</p>	
<p>NAME OF PROVIDER OR SUPPLIER</p> <p>BROOKDALE VALENCIA</p>		<p>STREET ADDRESS, CITY, STATE, ZIP CODE</p> <p>300 VALENCIA DRIVE SE ALBUQUERQUE, NM 87108</p>		
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<p>A 034</p>	<p>Continued From page 27</p> <p>NMAC.</p> <p>(10) The record of medication destruction shall be signed by the administrator or designee and the pharmacist and shall be kept on file at the facility.</p> <p>B. Consulting pharmacist. The facility shall maintain records demonstrating that the consulting pharmacist provides the following oversight and guidance.</p> <p>(1) Reviews the medication regimen as needed, but at least quarterly/every three (3) months, to determine that all medications and records are accurate and current. All irregularities shall be reported to the administrator of the facility and these irregularities shall be resolved by the administrator within seventy-two (72) hours.</p> <p>(2) A system of records of receipt and disposition of all drugs in sufficient detail to enable an accurate reconciliation.</p> <p>(3) Consultation shall be provided on all aspects of pharmacy services in the facility, including reference information regarding side effects and, when needed, physician consultation in cases involving the use of psychotropic medications.</p> <p>(4) The consulting pharmacist will be responsible for assuring that the facility meets all requirements for storage, labeling, destruction and documentation of medications as required by the state board of pharmacy, 16.19.11.10 NMAC and 7.8.2 NMAC. [7.8.2.34 NMAC - Rp, 7.8.2.35 NMAC, 01/15/2010]</p> <p>This REQUIREMENT is not met as evidenced by: 7.8.2.34 A (7)</p> <p>Refer to: NFPA (National Fire Prevention Association) 99.</p>	<p>A 034</p>		
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<p>STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION</p>	<p>(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:</p> <p>2055</p>	<p>(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____</p>	<p>(X3) DATE SURVEY COMPLETED</p> <p>C 08/04/2022</p>	
<p>NAME OF PROVIDER OR SUPPLIER</p> <p>BROOKDALE VALENCIA</p>		<p>STREET ADDRESS, CITY, STATE, ZIP CODE</p> <p>300 VALENCIA DRIVE SE ALBUQUERQUE, NM 87108</p>		
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A 034	<p>Continued From page 28</p> <p>2012 Edition.</p> <p>11.3 Cylinder and Container Storage Requirements.</p> <p>11.3.1* Storage for nonflammable gases equal to or greater than 85 m3 (3000 ft3) at STP shall comply with 5.1.3.3.2 and 5.1.3.3.3.</p> <p>11.3.2* Storage for nonflammable gases greater than 8.5 m3 (300 ft3), but less than 85 m3 (3000 ft3), at STP shall comply with the requirements in 11.3.2.1 through 11.3.2.3.</p> <p>11.3.2.1 Storage locations shall be outdoors in an enclosure or within an enclosed interior space of noncombustible or limited combustible construction, with doors (or gates outdoors) that can be secured against unauthorized entry.</p> <p>11.3.2.2 Oxidizing gases, such as oxygen and nitrous oxide, shall not be stored with any flammable gas, liquid, or vapor.</p> <p>11.3.2.3 Oxidizing gases such as oxygen and nitrous oxide shall be separated from combustibles or materials by one of the following:</p> <p>(1) Minimum distance of 6.1 m (20 ft)</p> <p>(2) Minimum distance of 1.5 m (5 ft) if the entire storage location is protected by an automatic sprinkler system designed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems</p> <p>(3) Enclosed cabinet of noncombustible construction having a minimum fire protection rating of 1/2 hour</p> <p>11.3.2.4 Gas cylinder and cryogenic liquid container storage shall comply with 5.1.3.5.12.</p> <p>11.3.2.5 Cylinder and container storage locations shall comply with 5.1.3.3.1.7 with respect to temperature limitations.</p> <p>11.3.2.6 Cylinder or container restraints shall comply with 11.6.2.3.</p> <p>11.3.2.7 Smoking, open flames, electric heating elements, and other sources of ignition shall be prohibited within storage locations and within 6.1</p>	A 034	
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A 034	<p>Continued From page 29</p> <p>m (20 ft) of outside storage locations.</p> <p>11.3.2.8 Cylinder valve protection caps shall comply with 11.6.2.3.</p> <p>11.3.2.9 Gas cylinder and liquefied gas container storage shall comply with 5.1.3.5.12.</p> <p>11.3.3 Storage for nonflammable gases with a total volume equal to or less than 8.5 m<sup>3</sup> (300 ft<sup>3</sup>) shall comply with the requirements in 11.3.3.1 and 11.3.3.2.</p> <p>11.3.3.1 Individual cylinder storage associated with patient care areas, not to exceed 2100 m<sup>2</sup> (22,500 ft<sup>2</sup>) of floor area, shall not be required to be stored in enclosures.</p> <p>11.3.3.2 Precautions in handling cylinders specified in 11.3.3.1 shall be in accordance with 11.6.2.</p> <p>11.3.3.3 When small-size (A, B, D, or E) cylinders are in use, they shall be attached to a cylinder stand or to medical equipment designed to receive and hold compressed gas cylinders.</p> <p>11.3.3.4 Individual small-size (A, B, D, or E) cylinders available for immediate use in patient care areas shall not be considered to be in storage.</p> <p>11.3.3.5 Cylinders shall not be chained to portable or movable apparatus such as beds and oxygen tents.</p> <p>11.3.4 Signs.</p> <p>11.3.4.1 A precautionary sign, readable from a distance of 1.5 m (5 ft), shall be displayed on each door or gate of the storage room or enclosure.</p> <p>11.3.4.2 The sign shall include the following wording as a minimum: <b>CAUTION: OXIDIZING GAS(ES) STORED WITHIN</b> (7) Medical gases (oxygen) and equipment used for the administration of inhalation therapy and for resuscitative purposes shall comply with the national fire protection association (NFPA) 99.</p>	A 034	
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<p>A 034</p>	<p>Continued From page 30</p> <p>Based on observation and interview, the facility failed to ensure that there was a precautionary sign posted on the door of the storage room enclosure and that oxygen cylinder tanks were stored securely and protected from accidental damage or dislocation.</p> <p>These deficient practices could likely result in the 48 (R #s 1-48) residents listed on the resident census, provided by the Executive Director 07/18/22, to be at risk of harm, injury, or death if first responders were not aware of oxygen storage areas during a fire and oxygen cylinder tanks were to fall over damaging the valve, causing them to depressurize during a fire, the oxygen feeds the fire, causing it to spread faster and/or the cylinder tanks act like missiles and hit a resident/staff/rescuer during a fire.</p> <p>The findings are:</p> <p>A. On 07/18/22 at 9:43 am, during observation of the oxygen storage room the following was observed:</p> <ol style="list-style-type: none"> <li>1. There was no precautionary sign posted on the door of the storage room enclosure.</li> <li>2. Two (2) tall oxygen cylinder tanks were observed to be unsecured and not protected from toppling over.</li> <li>3. One (1) tall oxygen cylinder tank was observed to be lying unsecured on its side with the potential to fall off the storage rack.</li> <li>4. Ten (10) tall oxygen cylinder tanks were observed to be stored in the horizontal position unsecured on a flat rack.</li> <li>5. Nine (9) short oxygen cylinder tanks were observed to be stored in the horizontal position unsecured on a flat rack.</li> </ol>	<p>A 034</p>	<ol style="list-style-type: none"> <li>1) The precautionary sign for oxygen storage will be posted on the storage room door. Excess oxygen cylinders have been removed from the premises. Storage racks obtained and cylinders are stored securely.</li> <li>2) Community associates will receive re-training on oxygen/gas safety.</li> <li>3) Executive Director/designee is responsible for this plan.</li> <li>4) To assist with compliance, a District Team member will conduct safety review at the next Site Visit.</li> <li>5) Completion Date: September 1, 2022.</li> </ol>	
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<p>STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION</p>	<p>(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:</p> <p>2055</p>	<p>(X2) MULTIPLE CONSTRUCTION</p> <p>A. BUILDING: _____</p> <p>B. WING _____</p>	<p>(X3) DATE SURVEY COMPLETED</p> <p>C 08/04/2022</p>
<p>NAME OF PROVIDER OR SUPPLIER</p> <p><b>BROOKDALE VALENCIA</b></p>		<p>STREET ADDRESS, CITY, STATE, ZIP CODE</p> <p><b>300 VALENCIA DRIVE SE ALBUQUERQUE, NM 87108</b></p>	

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A 034	Continued From page 31 B. On 07/19/22 at 9:24 am, during an interview with the Executive Director, she confirmed the oxygen room storage findings above.	A 034		
A 047	<p>7 NMAC 8.2.47 Lighting and Lighting Fixtures</p> <p>LIGHTING AND LIGHTING FIXTURES:</p> <p>A. All areas of the facility, including storerooms, stairways, hallways, and interior and exterior entrances shall be lighted to make the area clearly visible.</p> <p>B. Exits, exit-access ways and other areas used at night by residents and staff shall be illuminated by night lights or other continuous lighting.</p> <p>C. Lighting fixtures shall be selected and located to accommodate the needs and activities of the residents, with the comfort and convenience of the residents in mind.</p> <p>D. Lamps and lighting fixtures shall be shaded to prevent glare to the eyes of residents and staff, and protected from accidental breakage or shattering.</p> <p>E. Facilities with four (4) or more residents shall have emergency lighting to light exit passageways and the exterior area near the exits that activates automatically upon disruption of electrical service.</p> <p>F. Facilities with three (3) or fewer residents shall have a flashlight that is immediately available for use in lieu of electrically interconnected emergency lighting. [7.8.2.47 NMAC - Rp, 7.8.2.48 NMAC, 01/15/2010]</p> <p>This REQUIREMENT is not met as evidenced by: 7.8.2.47 E.</p>	A 047		

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

Division of Health Improvement

(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 047	<p>Continued From page 32</p> <p>Based on observation and interview the facility failed to ensure that all emergency lights in the facility were in working order.</p> <p>This deficient practice could likely result in the 48 (R #s 1-48) residents identified on the census provided by the Executive Director on 07/18/22 to be at risk of harm, injury, or death, if there is a power outage or other emergency requiring evacuation and the residents cannot see to safely exit the building.</p> <p>The findings are:</p> <p>A. On 07/18/22 at 9:28 am, during observation and testing of the facilities emergency lights, the emergency light outside of room number 267 failed to light up when tested.</p> <p>B. On 07/18/22 at 9:37 am, during observation and testing of the facilities emergency lights, the emergency light outside of room number 367 failed to light up when tested.</p> <p>C. On 07/18/22 at 9:41 am, during observation and testing of the facilities emergency lights, the emergency light outside of room number 156 failed to light up when tested.</p> <p>D. On 07/19/22 at 9:30 am, during an interview with the Executive Director, she confirmed that the facilities emergency lights listed above were not in working order.</p>	A 047	<ol style="list-style-type: none"> <li>1) Johnson Controls will replace broken emergency lights.</li> <li>2) Maintenance Director/designee will maintain contact with Johnson Controls for replacement.</li> <li>3) Maintenance Director/Executive Director are responsible for this plan.</li> <li>4) To assist in compliance, the Maintenance Director will check emergency lights monthly per Brookdale work order process.</li> <li>5) Completion Date: September 10, 2022</li> </ol>	
A 059	<p>7 NMAC 8.2.59 Windows</p> <p>WINDOWS:</p> <p>A. Each sleeping room shall be provided with an exterior window.</p>	A 059		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  2055	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  C 08/04/2022
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A 059	<p>Continued From page 33</p> <p>(1) The window shall be operable, screened and have a clear operable area of 5.7 square feet minimum; measured twenty (20) inches wide minimum and measured twenty-four (24) inches high minimum.</p> <p>(2) The top of the window sill shall not be more than forty-four (44) inches above the finished floor.</p> <p>B. Screens shall be provided on all operable windows.</p> <p>C. The proposed use of bars, grilles, grates or similar devices shall be reviewed and approved by the licensing authority prior to installation.</p> <p>D. Sleeping rooms, living rooms, activity room areas and dining room areas shall have a window area of at least one tenth (1/10) of the floor area with a minimum of ten (10) square feet. [7.8.2.59 NMAC - Rp, 7.8.2.52 NMAC, 01/15/2010]</p> <p>This REQUIREMENT is not met as evidenced by: 7.8.2.59 B.</p> <p>Based on observation and interview the facility failed to ensure that all of the facility's windows had screens.</p> <p>This deficient practice could likely result in the 48 (R #s 1-48) residents identified on the census provided by the Executive Director on 07/18/22, to be at risk of injury or illness if they are exposed to bugs/insects, allergens, or debris coming in through the windows missing screens.</p> <p>The findings are:</p> <p>A. On 07/18/22 at 1:00 pm, during observation of the exterior of the facility it was observed that</p>	A 059	<ol style="list-style-type: none"> <li>1) Window screens were replaced on the date of inspection.</li> <li>2) The maintenance team will be re-trained on Unit Turnover inspection process using Brookdale checklist.</li> <li>3) Maintenance Director/Executive Director are responsible for this plan.</li> <li>4) To assist in compliance, the Maintenance Director/designee will check exterior windows bi-weekly for a period of 3 months and following Unit Turnover renovations.</li> <li>5) Completion Date: August 4, 2022</li> </ol>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  2055	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B WING _____	(X3) DATE SURVEY COMPLETED  C 08/04/2022
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A 059	<p>Continued From page 34</p> <p>resident room number 166 two (2) windows did not have screens.</p> <p>B. On 07/19/22 at 9:28 am, during an interview with the Executive Director, she confirmed that resident room number 166 window screens were missing.</p>	A 059		