

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 5674	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - LA VIDA LLENA LIFECARE B. WING _____	(X3) DATE SURVEY COMPLETED 10/07/2009
NAME OF PROVIDER OR SUPPLIER LA VIDA LLENA LIFECARE RETIREMENT COM		STREET ADDRESS, CITY, STATE, ZIP CODE 10501 LAGRIMA DE ORO ROAD 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 01	OPENING REMARKS Surveyor: 25921 The following deficiencies were cited as a result of an annual survey conducted on October 7, 2009, for the Life Safety Code portion of the New Mexico Regulations Governing Requirements for Adult Residential Care Facilities 7.8.2 NMAC	A 01 10/31/09	The following Plan of Correction constitutes La Vida Llena Assisted Living Center Plan for Compliance in response to the DHS standard survey conducted on October 7, 2009 Preparation and /or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and /or executed solely because it is required by the provisions of federal and state law. A60 The Facility's practice failed to ensure that NMAC 8.2.60 Fire Alarms, Smoke Detectors And other Equipment worked properly according to federal and state codes. Horns on the Alarm system did not work in one area. Corrective Action for Affected Residents: No resident was affected nor was a specific resident identified in this deficiency. Procedure for identifying potential Affected Residents: All residents are potentially affected by the alleged deficient conduct contained herein, La Vida Llena will take corrective action in relation to all residents. Therefore no procedure for identifying potentially affected residents is necessary.	
A60	7 NMAC 8.2.60 Fire Alarms, Smoke Detectors, and other Equip 7.8.2.60 FIRE ALARMS, SMOKE DETECTORS AND OTHER EQUIPMENT: A. FIRE ALARM SYSTEM: A manual fire alarm system shall be provided. The manual fire alarm must be inspected and approved in writing by the fire authority having jurisdiction. EXCEPTION: Adult residential care facilities with three (3) or fewer residents are not required to have a fire alarm system. B. SMOKE AND HEAT DETECTION: Approved smoke detectors shall be installed on each floor to provide when activated an alarm which is audible in all sleeping areas. Areas of assembly such as the dining and living room must also be provided with smoke detectors. (1) Detectors shall be powered by the house electrical service and have battery back up. (2) Construction of new facilities or facilities remodeling or replacing existing smoke detectors shall provide detectors in common living areas and in each sleeping room. (3) Smoke detectors must be installed in corridors at no more than thirty (30) foot spacing. (4) Heat detectors shall be installed in all enclosed kitchens and also powered by the house electrical service. [9-24-76, 7-11-86, 1-11-90, 4-7-97; 7.8.2.60 NMAC - Rn, 7 NMAC 8.2.60, 8-31-00]	A60 <i>See Journal 10-28-09</i>		

Division of Health Improvement

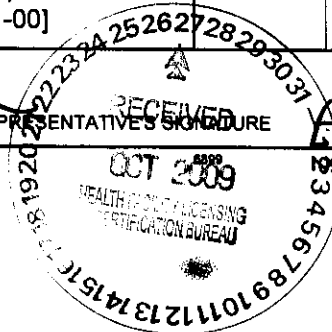
Sandra Stevens
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

STATE FORM

Administrator 10/21/09



199NN21

If continuation sheet 1 of 2

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A60	Continued From page 1 This REQUIREMENT is not met as evidenced by: Surveyor: 25921 Based on observation and staff interview, the facility's practice failed to ensure that the fire alarm strobes are maintained to synchronize to flash together in accordance with NFPA 72 (National Fire Alarm Code) and NFPA 70 (National Electric Code). This deficient practice potentially affects all staff, residents, and visitors throughout the facility. At the time of survey, the licensed capacity of the facility was 61, and the census was 25. The findings are: On October 7, 2009, between 8:00 am and 11:30 am, during a tour of the facility with the Director of Plant Operations, the surveyor observed the following: 1. During a fire drill that was conducted at 10:35 am, the fire alarm strobes throughout the building were not synchronized to flash together when two or more strobes are visible from any location. 2. During a fire drill that was conducted at 10:35 am, the fire alarm horns did not sound on the corridor from resident room 701 and resident room 731. These 30 rooms are located in two (2) separate smoke compartments. 3. The Director of Plant Operations stated that the system had just been tested and were working. He then stated that the alarm system would be corrected to function as required.	A60 10/31/09	CONTINUED FROM PAGE 1 Immediate Corrective Action 1. Siemens Building Technologies was called out to repair and bring the Fire Alarms up to code compliance. 2. Siemens arrived on October 7, 2009 to correct the problem. 3. 4 horns and strobes were found to be defective thus causing the rest of the horns in that hallway to not function properly. 4. The 4 horns and strobes were removed and the remaining horns worked properly. 5. Siemens is replacing the horns and strobes with new horns. See attached work order from Siemens. Measure Adopted for Systemic Change: 1. LVL fire alarms are tested monthly to ensure that the alarms are working properly, that includes the horns and Strobes. LVL will also continue using Siemens Building Technologies, or any other independent contractor, for quarterly testing of our Fire Alarm system as per Federal and State Code. These inspections will continue as schedule and are ongoing. 2. The policy, stating all smoke detectors and Fire Alarms monthly and quarterly testing will continued to be used.	

10/31/09

CONTINUED FROM PAGE 2

3. Inspections are documented on the smoke door and Fire Alarm inspection form is kept in the Life Safety Documentation II Book in the Plant Operations office at LVL.

Monitoring of Corrective Action and Quality Assurance:

Director of Plant Operation will monitor this process to ensure compliance on an ongoing basis and any significant occurrences reported to the Quality Assurance Committee monthly.