

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 2066	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - PONCE DE LEON B. WING _____	(X3) DATE SURVEY COMPLETED 09/01/2009
NAME OF PROVIDER OR SUPPLIER PONCE DE LEON		STREET ADDRESS, CITY, STATE, ZIP CODE 640 ALTA VISTA STREET SANTA FE, NM 87505		
(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: 21700 The following deficiencies were cited as a result of a Life Safety Code survey conducted on 09/1/09 for New Mexico Regulations Governing Requirements for Adult Residential Care Facilities 7.8.2 NMAC.	A 01		
A44	7 NMAC 8.2.44 Hazardous Areas 7.8.2.44 HAZARDOUS AREAS: A. Hazardous areas, as defined per NFPA 101 (Life Safety Code), on the same floor as, and in or abutting a primary means of escape or a sleeping room shall be protected by either; (1) Enclosure of at least one hour fire rating with self closing or smoke operated automatic closing fire doors having a 3/4 hour rating or; (2) Automatic fire protection (sprinkler) and separation of hazardous area with any doors self-closing or automatic-closing on smoke detection. (3) Other hazardous areas shall be enclosed with walls having at least a twenty (20) minute fire rating and doors equivalent to 1 3/4 inch solid bonded wood core, operated by self-closures or automatic closing on smoke detection. B. All boiler, furnace or fuel fired water heater rooms shall be protected from other parts of the building by construction having a fire resistance rating of not less than one-hour. Doors to these rooms shall be 1-3/4" solid core. EXCEPTION: Adult residential care facilities with three (3) or fewer residents are not required to have a fire resistance rating of not less than one-hour or the 1-3/4" solid core door. [7-1-64, 9-15-70, 9-24-76, 7-11-86, 4-7-97; 7.8.2.44 NMAC - Rn, 7 NMAC 8.2.44, 8-81-08]	A44	A44 - The defeciency will be addressed by the installation of a suitable automatic (sprinkler) extinguishing system as defined per NFPA 101. Fred Rael, maintenance supervisor and Charles Runkle will be responsible for the completion of the project. The project will be completed by November 15, 2008. The decrepancy will be addressed by Fred Rael, maintenance director.	11/15/09

Scanned 9/2/09

Division of Health Improvement

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

STATE FORM

TITLE *Exec. Dir.*

(X6) DATE *9/2/09*



Division of Health Improvement

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A44	Continued From page 1 This REQUIREMENT is not met as evidenced by: Surveyor: 21700 Based on observation, the facility failed to assure all hazardous areas are protected by a fire barrier having a 1-hour fire resistance rating with self closing or smoke operated automatic closing fire doors having a 3/4 hour rating or be provided with an automatic (sprinkler) extinguishing system, as defined per NFPA 101 (Life Safety Code). This deficient practice potentially affects all residents and staff throughout the facility. The licensed capacity of the facility is 63, the census during the survey was 42. The findings are: On September 1, 2009, during a tour of the facility with the Director of Maintenance, the Life Safety Code Surveyor observed the following: 1. At 3:55 pm, the maintenance shop was not sprinklered and the door was being propped open with the use of a door stop device. This room was not protected by a 1-hour fire barrier and rated door assembly. a. The maintenance shop measured at 209 square feet and contained numerous combustible items including, paper and cardboard products. The shop also contained a fire cabinet, paints, cleaning/corrosive products, and shop tools to include a grinder wheel. b. The Administrator and the Director of Maintenance acknowledged this finding at the exit conference on 9/1/09.	A44		
A48	7 NMAC 8.2.48 Lighting & Lighting Fixtures 7.8.2.48 LIGHTING AND LIGHTING FIXTURES:	A48		

Division of Health Improvement

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A48	<p>Continued From page 2</p> <p>A. All areas of the facility, including storerooms, stairways, hallways, and interior and exterior entrances must 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 must be illuminated by night lights or other continuous lighting.</p> <p>C. Lighting fixtures must 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 must be shaded to prevent glare to the eyes of residents and staff, and protected from accidental breakage or shattering.</p> <p>E. A facility must be provided with emergency lighting to light exit passageways which will activate automatically upon disruption of electrical service. EXCEPTION: Adult residential care facilities with three (3) or fewer residents may have a flashlight that is immediately available for use in lieu of electrically interconnected emergency lighting. [7-1-64, 9-15-70, 9-24-76, 7-11-86, 4-7-97; 7.8.2.48 NMAC -Rn, 7 NMAC 8.2.48, 8-31-00]</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 21700 Reference NFPA 101, 1997 Edition Section 5-9.3 requires that the emergency lighting system be tested every 30 days for at least 30 seconds and annually for at least 90 minutes. It also requires that written records of inspections and tests be maintained for inspection by the authority having jurisdiction.</p>	A48	<p>A 48 - All lights will be tested monthly for 30 seconds and a log of the results will be maintained. Faulty lights will be replaced immediately by Ponce maintenance staff. Additionally all emergency lights will be inspected annually by an outside agency. Records will be kept accessible for review. All defective lighting will be replaced immediately.</p>	11/15/09

Division of Health Improvement

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A48	Continued From page 3 Based on observation and testing, the facility's practice failed to ensure emergency lighting is operational throughout the facility to illuminate all means of egress in the event of disruption of electrical service. This deficient practice has the potential to affect staff and residents throughout the facility. The licensed capacity is 63, and the census during survey was 42. The findings are: On September 1, 2009, during a tour of the facility with the Director of Maintenance, the Life Safety Code Surveyor observed the following. 1. At 3:25 pm, the emergency light fixture located at the main living room failed to illuminate when tested. a. The Administrator and the Director of Maintenance acknowledged the finding at the exit conference on 9/1/09.	A48		
A59	7 NMAC 8.2.59 Fire Clearance & Inspections 7.8.2.59 FIRE CLEARANCE AND INSPECTIONS: A. Written documentation from the State Fire Marshall's office or Fire Prevention Authority having jurisdiction indicating a facility's compliance with applicable fire prevention codes shall be submitted to the Licensing Authority prior to issuance of a initial license. B. Each facility shall request from the local fire prevention authorities an annual fire inspection. If the policy of the local fire department does not provide for annual inspection of the facility, the facility will document the date the request was made and to whom and then contact licensing authorities. If the local fire prevention authorities do make annual inspections, a copy of the latest inspection must	A59	A 59 - This deficiency has been corrected by the creation of a yearly reminder on the Executive Director's computer for the yearly fire inspection. Further the binder containing the monthly fire drills has a reminder of the annual inspection due on it's inside cover. Fred Rael maintenance director and Charles Runkle executive	09/03/09

Division of Health Improvement

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A59	Continued From page 4 be kept on file in the facility. [7-1-64, 9-24-76, 7-11-86, 1-11-90, 4-7-97; 7.8.2.59 NMAC - Rn, 7 NMAC 8.2.59, 8-31-00] This REQUIREMENT is not met as evidenced by: Surveyor: 21700 Based on documentation review, the facility failed to keep a record of the annual inspection report of the Local Fire Authority, as required by the Life Safety Code (NFPA 101) and NMAC 7.8.2. This deficient practice affects all staff and residents throughout the facility. At the time of survey, the census was 42 and the licensed capacity was 63. The findings are: On September 1, 2009, during a review of the facility's documentation with the Director of Maintenance, the Life Safety Code Surveyor observed the following: 1. At 10:45 am, there was no evidence of an annual local Fire Authority inspection having been conducted within the last 12 months. The last documented inspection from the local Fire Authority was conducted on 10/29/07.	A59	director are responsible for the scheduling of the annual fire inspection. .	
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:	A60	A 60 - The facility will have all smoke detectors tested for sensitivity annually by an outside vendor. Fred Rael maintenance director and Charles Runkle, executive director are responsible for scheduling the test and maintaining the records.	10/15/09

Division of Health Improvement

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A60	<p>Continued From page 5</p> <p>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.</p> <p>(1) Detectors shall be powered by the house electrical service and have battery back up.</p> <p>(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.</p> <p>(3) Smoke detectors must be installed in corridors at no more than thirty (30) foot spacing.</p> <p>(4) Heat detectors shall be installed in all enclosed kitchens and also powered by the house electrical service.</p> <p>[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]</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 21700 Based on documentation review, the facility's practice failed to ensure the fire alarm system and its components are inspected and maintained in accordance with (NFPA 72 H-1984,4-1), National Fire Alarm Code which requires sensitivity testing of the smoke detection devices be tested the first year after installation and every other year after until detectors fail. This deficient practice potentially affects all residents and staff throughout the facility. The licensed capacity of the facility was 63, the census during the survey was 42. The findings are:</p> <p>On September 1, 2009, during a review of the facility maintenance records with the Director of Maintenance, the Life Safety Code Surveyor observed the following.</p>	A60		

Division of Health Improvement

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A60	Continued From page 6 1. At 10:55 am, there was no evidence that sensitivity testing was ever performed on the facility smoke detectors. 2. The fire alarm system inspection report dated 11/17/08 stated, "Found zone 12 smoke detectors the cause of troubles to false alarms." The fire alarm system inspection report also stated, "Replace all smoke detectors over 10 years of age." Based on observation and interview, the facility's practice failed to ensure that approved smoke detectors were installed in areas of assembly. 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 63, and the census was 42. The findings are: On September 1, 2009, during a tour of the facility with the Director of Maintenance, the Life Safety Code Surveyor observed the following: 3. At 1:15 pm, the main dining room was not equipped with smoke detection. a. During interview with the Administrator, it was explained that residents do use the main dining room on occasion. 4. At 1:25 pm, the main living room was not equipped with smoke detection. a. During interview with the Administrator, it was explained that residents do use the main living room on occasion.	A60		

Division of Health Improvement

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A60	Continued From page 7 5. At 1:35 pm, the activities room was not equipped with smoke detection. a. During interview with the Administrator, it was explained that residents do use the activities room on occasion. Based on observation, the facility's practice failed to ensure that approved heat detectors were installed in enclosed kitchens. 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 63, and the census was 42. The findings are: On September 1, 2009, during a tour of the facility with the Director of Maintenance, the Life Safety Code Surveyor observed the following: 6. At 2:35 pm, the kitchen was not equipped with a heat detector. a. The Administrator and the Director of Maintenance acknowledged this finding at the exit conference on 9/1/09. Based on observation, the facility's practice failed to ensure that the fire alarm system and its components are maintained in accordance with NFPA 72 (National Fire Alarm Code). This deficient practice potentially affects all residents and staff throughout the facility. The licensed capacity of the facility is 63, the census during the survey was 42. The findings are: On September 1, 2009, during a tour of the facility with the Director of Maintenance, the Life Safety Code Surveyor observed the following.	A60	A 60 - To correct these discrepancies smoke detectors will be installed in the main dining room, main living room and the activities room. Fred Rael maintenance director and Charles Runkle executive director are responsible for scheduling of the installation. A 60 - Heat detectors, as specified in NFPA72, will be installed in the kitchen. Fred Rael maintenance director and Charles Runkle executive director are responsible for scheduling the installation.	11/30/09 11/30/09

Division of Health Improvement

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A60	Continued From page 8 7. The door to the 1st floor laundry was equipped with a magnetic hold open devise, which is designed to release with activation of the fire alarm system. The door failed to close when tested. The door was binding along the floor. a. The Administrator and the Director of Maintenance acknowledged this finding at the exit conference on 9/1/09.	A60	A 60 - All magnetic doors will be checked monthly for proper operation. A log of the inspection and any remedial action needed will be kept by Fred Rael maintenance director. The log will be reviewed and signed by Charles Runkle, Executive Director. Defective equipment will be repaired immediately.	10/15/09
A62	7 NMAC 8.2.62 Fire Extinguishers 7.8.2.62 FIRE EXTINGUISHERS: A. As approved by the State Fire Marshall or Fire Prevention Authority having jurisdiction must be located in the facility. Facilities must as a minimum have two (2) 2A10BC fire extinguishers, one (1) located in the kitchen or food preparation area, and one (1) centrally located in the facility. All fire extinguishers shall be inspected yearly and recharged as needed. All fire extinguishers must be tagged noting the date of inspection. B. Fire extinguishers, alarm systems, automatic detection equipment, and other fire fighting equipment must be properly maintained and inspected as recommended by the manufacturer, State Fire Marshall, or Fire Authority having jurisdiction. [7-1-64, 9-24-76, 7-11-86, 4-7-97; 7.8.2.62 NMAC - Rn, 7 NMAC 8.2.62, 8-31-00] This REQUIREMENT is not met as evidenced by: Surveyor: 21700 Reference Tag B. FIRE EXTINGUISHERS: Reference NFPA 10, Standard for Portable Fire Extinguishers, 1998 Edition: 4-3 Inspection.	A62		

Division of Health Improvement

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A62	<p>Continued From page 9</p> <p>4-3.1* Frequency. Fire extinguishers shall be inspected when initially placed in service and thereafter at approximately 30-day intervals. Fire extinguishers shall be inspected at more frequent intervals when circumstances require.</p> <p>4-3.2* Procedures. Periodic inspection of fire extinguishers shall include a check of at least the following items: (a) Location in designated place (b) No obstruction to access or visibility (c) Operating instructions on nameplate legible and facing outward (d) * Safety seals and tamper indicators not broken or missing (e) Fullness determined by weighing or " hefting " (f) Examination for obvious physical damage, corrosion, leakage, or clogged nozzle (g) Pressure gauge reading or indicator in the operable range or position (h) Condition of tires, wheels, carriage, hose, and nozzle checked (for wheeled units) (i) HMIS label in place</p> <p>Based on observation, the facility's practice failed to ensure that all portable fire extinguishers are inspected monthly, documented and maintained in accordance with NFPA 10, (Standard for Portable Fire Extinguishers). This deficient practice had the potential to affect all staff and residents of the facility. The licensed capacity of the facility was 63, the census during the survey was 42. The findings are:</p> <p>On September 1, 2009, during a tour of the facility with the Director of Maintenance, the Life</p>	A62	<p>A 62 - The violation will be corrected by increasing the monthly inspection of apartment fire extinguishers to bi-weekly .The facility will monitor its corrective action by bi-weekly inspections and maintenance of a log of the inspections by the Health and Wellness Director.</p>	10/15/09

Division of Health Improvement

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A62	Continued From page 10 Safety Code Surveyor observed the following. 1. At 2:40 pm, the portable K-class fire extinguisher located within the kitchen was not inspected at least every month (not to exceed 30 -days) by staff. a. The "K" class fire extinguisher was last signed and inspected by staff in August of 2008. b. The Administrator and the Director of Maintenance acknowledged this finding at the exit conference on 9/1/09.	A62		
A63	7 NMAC 8.2.63 Staff & Resident Fire & Safety Training 7.8.2.63 STAFF AND RESIDENT FIRE AND SAFETY TRAINING: A. All staff personnel of the facility must know the location of and be instructed in proper use of fire extinguishers and other procedures to be observed in case of fire or other emergencies. The facility should request the local fire prevention authority to give periodic instructions in the use of fire prevention and techniques of evacuation. B. Facility staff must be instructed as part of their duties to constantly strive to detect and eliminate potential safety hazards, such as loose handrails, frayed electrical cords, blocked exits or exit-ways, and any other condition which could cause burns, falls, or other personal injury to the residents or staff. C. Each new resident must upon being accepted into the facility be given an orientation tour of the facility to include, but not be limited to, the location of the exits, fire extinguishers, and telephones, and shall be instructed in action to be taken in case of fire or other emergency. D. Fire Drills: The facility must conduct at	A63	A 63 - The violation will be corrected by adhering to the required fire drill schedule and procedures specified in 7NMAC 8.2.63. The facility will monitor its corrective action by maintaining a complete record of the monthly fire drills Fred Rael maintenance director is responsible for conducting the drills. Drills will be co-signed by Charles Runkle executive director.	10/15/09

Division of Health Improvement

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A63	<p>Continued From page 11</p> <p>least one (1) fire drill each month:</p> <p>(1) Fire drills must be held at different times of the day.</p> <p>(2) The fire alarm system or detector system in the facility shall be used in the conduct of fire drills.</p> <p>(3) In the conduct of fire drills, emphasis must be placed upon orderly evacuation under proper discipline rather than upon speed.</p> <p>(4) A record of fire drills held must be maintained on file in the facility. Such record must show date and time of the drill, number of personnel participating in the drill, any problem noted during the drill and the evacuation time in total minutes.</p> <p>(5) The local fire department should be requested to supervise and participate in fire drills. [9-24-76, 7-11-86, 1-11-90, 4-7-97; 7.8.2.63 NMAC - Rn, 7 NMAC 8.2.63, 8-31-00]</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 21700</p> <p>Based on record review and staff interview, the facility failed to conduct fire drills at least quarterly on every shift to assure preparedness for emergency response. Fire drills shall not exceed 90-day spacing between drills on each shift. This deficient practice affects all staff and residents throughout the facility. At the time of survey, the census was 42 and the licensed capacity was 63. The findings are:</p> <p>On September 1, 2009, during a tour of the facility with the Director of Maintenance, the Life Safety Code Surveyor observed the following:</p>	A63		

Division of Health Improvement

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A63	<p>Continued From page 12</p> <p>1. During interview with the Director of Maintenance, it was stated that there are three (3) staff shifts per day as follows: Day shift from 6:00 am to 2:00 pm. Evening shift from 2:00 pm to 10 pm. Night shift from 10:00 pm to 6:00 am.</p> <p>a.. There was no evidence of a fire drill for the evening shift (2pm-10pm) between the dates of 3/18/09 and 9/1/09.</p> <p>b.. There was no evidence of a fire drill for the night shift (10pm-6am) for the past 12 months.</p> <p>c. The Administrator and Director of Maintenance acknowledged this finding at the exit conference on 9/1/09.</p> <p>Based on record review and staff interview, the facility failed to conduct fire drills with the use of the fire alarm system and or detector system to assure preparedness for emergency response and be trained in proper procedures in regards to the fire alarm system. This deficient practice affects all staff and residents throughout the facility. At the time of survey, the census was 42 and the licensed capacity was 63. The findings are:</p> <p>On September 1, 2009, during a tour of the facility with the Director of Maintenance, the Life Safety Code Surveyor observed the following:</p> <p>2. At 3:45 the surveyor requested to conduct a fire drill by using the fire alarm pull station.</p> <p>a. The Director of Maintenance stated, "I have never used a pull station to conduct a fire drill and I am not sure that I will be able to reset the system." It was also stated, "I have never been trained how to reset the fire pull stations."</p>	A63		

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 2066	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - PONCE DE LEON B. WING _____	(X3) DATE SURVEY COMPLETED 09/01/2009
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A63	Continued From page 13 b. At this time, the Director of Maintenance explained that previous fire drills were conducted by means of smoke detectors within resident rooms. It was explained that the smoke detectors located in resident rooms are not connected to the facilities main fire alarm system but rather they are monitored through the use of hand held radios. The Director of Maintenance continued by saying, "Only the corridor smoke detectors are connected to the facility fire alarm system." c. The Administrator and the Director of Maintenance acknowledged this finding at the exit conference on 9/1/09.	A63		