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PRINTED: 05/11/2015
FORM APPROVED

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 2066	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 04/09/2015
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NAME OF PROVIDER OR SUPPLIER
PONCE DE LEON

STREET ADDRESS, CITY, STATE, ZIP CODE
**640 ALTA VISTA
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 000	Initial Comments The following deficiencies were cited during a complaint on 04/09/15 for the New Mexico requirements for Assisted Living for Adults, 7.8.2 NMAC. Complaint # NM00029660 was substantiated.	A 000	The following is the plan of correction for Ponce de Leon regarding the statement Of deficiencies, 04/09/2015. 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 A 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 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.	
A 032	7 NMAC 8.2.32 Reporting of Incidents REPORTING OF INCIDENTS: A. The facility shall insure that all suspected cases or known incidents of resident abuse, neglect or exploitation are reported in accordance with 7.1.13 NMAC. (1) The facility shall also report any incident or unusual occurrence which s 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, 7.8.2.33 NMAC,	A 032		

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Division of Health Improvement
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

[Signature] 6/15/15
STATE FORM 6499
[Signature] 7/4/15
[Signature] 8/18/15

TITLE
Executive Director
DATE

RECEIVED
AUG 20 2014
HEALTH FACILITY LICENSING
& CERTIFICATION BUREAU

Division of Health Improvement

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A 032	Continued From page 1 01/15/2010] This REQUIREMENT is not met as evidenced by: REFERENCE 7.8.2.32 Based on record review and interview, the facility failed to ensure that incidents that threaten the health and safety of residents were reported to the Licensing Authority as required within twenty-four (24) hours or by the next business day, if it is a weekend or a holiday. If the facility is not reporting incidents in which residents sustain injuries that require emergency services then, residents may be at further risk for injury or neglect. The findings are: A. Record review of Incident logs dated 01/01/15 to 03/23/15 revealed: 1. R #58 was transfered to the Emergency Room on date 01/26/15 and 02/21/15 following a fall in the facility resulting in head lacerations. There was no record that a state incident report was completed. 2. R #62 was transfered to the Emergency Room on date 03/02/15 following a fall in the facility resulting in head laceration. There was no record that a state incident report was completed. 3. R # 61 was transfered to the Emergency Room on 03/14/15 following a fall in the facility for pain to right leg, hip and lower back. There was no record that a state incident report was completed. B. On 04/09/15 at 10:00 am during interview with HWD when asked what are the State Agency's requirements for reporting incidents she replied, "We were told by corporate that we no longer had to report to the State, to just enter the reports into	A 032	A 032 7NMAC 8.2.32 Reporting Incidents Reference 7.8.2.32 4/10/2015 COMPLIANT Item A-R#58, R#61 and R#62 Incident packets (exhibit A) were supplied to Nurses and Resident Assistants. *Nurses or Resident assistants will complete initial incident reports at time of incident. *Health and Wellness Director will review all incident reports and submit within 24hours. *Health and Wellness Director will submit 5 day follow up. Item B Review and re-training of DOH Incident Reporting, Brookdale Policy and Procedure and Reportable Event Grid with all Nurses to comply with NMDOH regulations. (exhibit B)	

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A 032	Continued From page 2 our system, and print them out for our log book."	A 032		
A 035	7 NMAC 8.2.35 Medication MEDICATIONS: Administration of medications or staff assistance with self-administration of medications shall be in accordance with state and federal laws. No medications, including over-the-counter medications, PRN (when needed) medications, or treatment shall be started, changed or discontinued by the facility without an order from the physician, physician assistant or nurse practitioner and with entry into the resident's record. A. State board of nursing licensed or certified health care professionals are responsible for the administration of medications. Administration may only be performed by these individuals. B. Facility staff may assist a resident with the self-administration of medications if written consent by the resident is given to the administrator of the facility or the administrator's designee. If the resident is incapable of giving consent, the surrogate decision maker named in accordance with New Mexico law may give written consent for assistance with self-administration of medications. All staff that assist with self-administration of medications shall have successfully completed a state approved assistance with self-administration of medication training program or be licensed or certified by the state board of nursing. C. PRN (pro re nada) medication. (1) Physician or physician extender's orders for PRN medications shall clearly indicate the circumstances in which they are to be used, the number of doses that may be given in a 24-hour period and indicate under what circumstances the primary care practitioner (PCP) is to be notified.	A 035		

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A 035	Continued From page 3 (2) The utilization of PRN medications shall be reviewed routinely. Frequent or escalating use of PRN medications shall be reported to the PCP. D. Only a licensed nurse (RN or LPN) shall administer any medications or conduct any invasive procedures provided by the following routes: intravenous (IV), subcutaneous (SQ), intramuscular (IM), vaginal or rectal. Only a licensed nurse shall administer non-premixed nebulizer treatments. E. The facility shall have medication reference material that contains information relating to drug interactions and side effects on the premises. Staff that assist in the self-administration of medications shall know interactions or possible side effects that might occur. F. Medications prescribed for one resident shall not be used for another resident. G. Medication assistance record (MAR). For residents who are not independent and require assistance with self administration, the facility shall have a MAR that documents the details of the residents' medication, including PRN and over-the-counter medication that is assisted with self-administration by qualified staff or administered to the resident by licensed or certified staff. The Information in the MAR shall include: (1) the resident's name; (2) any known allergies to medication that the resident has; (3) the name of the resident's PCP or the prescriber of the medication; (4) the diagnosis or reason for the medication; (5) the name of the medication, including the drug product brand name and the generic name; (6) notation if the medication is a schedule II-IV drug; (7) the dosage of the medication;	A 035		

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A 035	<p>Continued From page 4</p> <p>(8) the strength of the medication; (9) the frequency or how often the medication is to be taken or given; (10) the route of delivery for the medication (mouth, eye, ear, other); (11) the method of delivery for the medication (pills, drops, IM injection, other); (12) the date that the medication was started or discontinued; (13) any change in the medication order; (14) pre-medication information (i.e., pulse, respiration, blood pressure, blood sugar) as required by the medication order; (15) the date and time that the medication is self-administered, administered with assistance or is administered; (16) the initials and signature of the person assisting with or administering the medication; (17) the desired results obtained from or problems encountered with the medication (pain relieved, allergic reaction, etc.); (18) any refused dose of medication; (19) any missed dose of medication; and (20) any medication error.</p> <p>H. No medication shall be stopped or started without specific orders from the primary care physician.</p> <p>I. If a resident refuses to take a prescribed medication, it shall be documented and the facility shall report it to the prescriber.</p> <p>J. A suspected adverse reaction to a medication shall be documented on the MAR and reported immediately to the PCP and the resident's surrogate decision maker. If applicable, emergency medical treatment shall be arranged. Documentation of the event shall be kept in the resident's record.</p> <p>K. Prescription medication, other than blister packs and unit dose containers, shall be kept in</p>	A 035		

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A 035	<p>Continued From page 5</p> <p>the original container with a pharmacy label that includes the following:</p> <p>(1) the resident's name;</p> <p>(2) the name of the medication;</p> <p>(3) the date that the prescription was issued;</p> <p>(4) the prescribed dosage and the instructions for administration of the medication; and</p> <p>(5) the name and title of the prescriber.</p> <p>L. Any medication that is removed from the pharmacy container or blister pack shall be given immediately and documented by the staff that assisted with the medication delivery.</p> <p>M. The facility shall report all medication errors to the physician, documentation of medication errors and the prescriber's response shall be kept in the resident's record.</p> <p>N. The facility shall develop and follow a written policy for unused, outdated, or recalled medications kept in the facility in accordance with 16.19.11.10 NMAC.</p> <p>[7.8.2.35 NMAC - Rp, 7.8.2.36 NMAC, 01/15/2010]</p> <p>This REQUIREMENT is not met as evidenced by: Reference 7.8.2.35</p> <p>Based on observation, record review and interview, the facility failed to ensure that medications are secure and out of reach of residents, and that the facility's caregivers are documenting on the Medication Administration Record (MAR) when providing assistance with medication for 4 residents (R #5, 22, 41, 57,) of 4 (R #5, 22, 41, 57) records reviewed for medication compliance. If medications are not securely stored, then residents can take medications not prescribed to them which could</p>	A 035		

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A 035	Continued From page 6 result in adverse medical interactions. If staff are not documenting when medication assistance is being provided, then staff can be misled when a resident was assisted with medication, resulting in over or under-medicating residents. The findings are: A. On 04/09/15 at 11:00 am, during observation of the Medication Room, eye drop medications, topical medications, and skin patches were being stored on the counter in clear plastic bins. The door to the Medication Room was unlocked and accessible to residents. B. On 04/09/15 at 11:30 am, during interview, the Health and Wellness Director (HWD) stated that she was unaware that eye medication, topical medication and skin patch medication should be secured, stating "That's how it was when I got here." C. Record review of the MAR for R #57 for 03/01/15 to 03/31/15 revealed Exelon (medication used to treat Alzheimer's disease) 4.6 milligram (mg) to be given daily was not documented that it had been given. D. On 04/09/15 at 11:45 am, during interview with HWD when asked what the requirement was for documenting medication staff assists she replied, "All medications are listed on the residents' MAR, and initialed when given. However, the Exelon patches are documented on the Flow Sheet." HWD confirmed Exelon medication patch for R #57 are not documented on that MAR as being given.	A 035	A 035 NMAC 8.2.35 Medication Reference 7.8.2.34 4/9/2015 COMPLIANT Item A and B All eye drops and topical creams were moved into locked med cart. Item C and D All skin patches will be documented as given on MAR and location for application and removal will be documented on Transdermal Patch Application Record (exhibit C).	
A 036	7 NMAC 8.2.36 Nutrition	A 036		

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A 036	Continued From page 7 NUTRITION: The facility shall provide planned and nutritionally balanced meals from the basic food groups in accordance with the " recommended daily dietary allowance " of the American dietetic association, the food and nutrition board of the national research council, or the national academy of sciences. Meals shall meet the nutritional needs of the residents in accordance with the " 2005 USDA dietary guidelines for Americans. " Vending machines shall not be considered a source of snacks. A. Dietary services policies and procedures. The facility will develop and implement written policies and procedures that are maintained on the premises and that govern the following requirements. (1) Meal service. The facility shall: (a) serve at least three (3) meals or their equivalent each day at regular times with no more than sixteen (16) hours between the evening meal and morning meal with snacks freely available; (b) provide snacks of nourishing quality and post on the daily menu; (c) develop menus enjoyed by the residents and served at normal intervals appropriate to the residents ' preferences; (d) post the weekly menu, including snacks where residents and families are able to view it; posted menus shall be followed and any substitution shall be of equivalent nutritional value and recorded on the posted menu; identical menus shall not be used within a one (1) week cycle; (e) have special menus or meal items following guidelines from the resident ' s physician for residents who have medically prescribed special diets; (f) serve all residents in a dining room except for	A 036		

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A 036	Continued From page 8 residents with a temporary illness, or with documented specific personal preference to have meals in their room; (g) allow sufficient time for meals to enable residents to eat at a leisurely pace and to socialize; and (h) contact the resident ' s PCP within forty-eight (48) hours if a resident consistently refuses to eat. (2) Staff in-service training. The facility shall provide an in-service training program for staff that are involved in food preparation at orientation and at least annually and that includes: (a) instruction in proper food storage; (b) preparation and serving food; (c) safety in food handling; (d) appropriate personal hygiene; and (e) infectious and communicable disease control. B. Dietary records. The facility shall maintain the following documentation onsite: (1) a systematic record of all menus and revisions, including snacks, for a minimum of thirty (30) calendar days; (2) a systematic record of therapeutic diets as prescribed by a PCP; (3) a copy of the most recent licensing inspection and for facilities with 10 or more residents, a copy of the New Mexico environment department inspection with notations made by the facility of action taken to comply with recommendations or citations; and (4) a daily log of the recorded temperatures for all facility refrigerators, freezers and steam tables maintained and available for inspection for thirty (30) calendar days. C. Clean and sanitary conditions. All practices shall be in accordance with the standards of the state environment department, pursuant to 7.6.2 NMAC.	A 036		

Thomas J. Lopez
7/4/15

Division of Health Improvement

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A 036	<p>Continued From page 9</p> <p>(1) Kitchen sanitation. (a) Equipment and work areas shall be clean and in good repair. Surfaces with which food or beverages come into contact shall be of smooth, impervious material free of open seams, not readily corrodible and easily accessible for cleaning. (b) Utensils shall be stored in a clean, dry place protected from contamination. (c) The walls, ceiling and floors of all rooms that food or drink is stored, prepared or served shall be kept clean and in good repair.</p> <p>(2) Washing and sanitizing kitchenware. (a) All reusable tableware and kitchenware shall be cleaned in accordance with procedures that include separate steps for prewashing, washing, rinsing and sanitizing. (b) Proper dishwashing procedures and techniques shall be utilized and understood by the dishwashing staff. (c) Periodic monitoring of the operation of the detergent dispenser, washing, rinsing and sanitizing temperatures shall be performed and documented. (d) When a dishwashing machine is utilized, the cleanliness of the machine, its jets and its thermostatic controls shall be monitored and documented by the facility. A monthly log of the recorded temperature of the dishwasher shall be maintained in the facility and available for inspection.</p> <p>(3) Sinks for hand washing shall include hot and cold running water, hand-washing soap and disposable towels.</p> <p>(4) All garbage and kitchen refuse that is not disposed of through a garbage disposal unit shall be kept in watertight containers with close-fitting covers and disposed of daily in a safe and sanitary manner.</p>	A 036		

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A 036	<p>Continued From page 10</p> <p>(5) Cooks and food handlers shall wear clean outer garments and hair nets or caps and shall keep their hands clean at all times when engaged in handling food, drink, utensils or equipment in accordance with the local health authority. Disposable gloves shall be used in accordance with the local health authority.</p> <p>D. Food management. The facility shall store, prepare, distribute and serve food under sanitary conditions and in accordance with the regulations governing food establishments of local health authority having jurisdiction, 7.6.2 NMAC.</p> <p>(1) The facility shall ensure that a minimum of a three (3) calendar day supply of perishables and a five (5) calendar day supply of non-perishables or canned foods is available for the residents.</p> <p>(2) The facility refrigerator and freezer shall have an accurate thermometer which reads within or not more than plus or minus three (3) degrees fahrenheit of the required temperature, located in the warmest section of the refrigerator and freezer and shall be accessible and easily read.</p> <p>(a) The temperature of the refrigerator shall be thirty-five (35) - forty-one (41) degrees fahrenheit.</p> <p>(b) Freezer temperatures shall be maintained at zero (0) degrees fahrenheit or below.</p> <p>(3) Refrigerators and freezers shall be kept clean and sanitary at all times. Food stored in refrigerators and freezers shall be covered, dated and labeled. Unused leftover food shall be discarded after three (3) calendar days.</p> <p>(4) Steam tables, hot food tables, slow cookers, crock pots and other hot food holding devices shall not be used in heating or reheating food. Hot food temperatures shall be checked periodically to insure that a minimum of one hundred forty (140) degrees fahrenheit is maintained.</p> <p>(5) Medication, biological specimens, poisons,</p>	A 036		

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A 036	<p>Continued From page 11</p> <p>detergents and cleaning supplies shall not be kept in the same storage areas used for storage of foods. Medications shall not be stored in the refrigerator with food; an alternate refrigerator for medication shall be used pursuant to Subsection B of 7.6.2.8 NMAC.</p> <p>(6) Canned or preserved foods shall be procured from sources that process the food under regulated quality and sanitation controls. This does not preclude the use of local fresh produce. The facility shall not use home-canned foods.</p> <p>(7) Dry or staple food items shall be stored at least six (6) inches off the floor in a ventilated room that is not subject to sewage, waste water back-flow or contamination by condensation, leakage, rodents or vermin.</p> <p>(8) The facility shall ensure the following:</p> <p>(a) all perishable food is refrigerated and the temperature is maintained no higher than forty-one (41) degrees fahrenheit;</p> <p>(b) the temperature for all hot foods is maintained at one hundred forty (140) degrees fahrenheit; and</p> <p>(c) all displayed or transported food is protected from environmental contamination and maintained at proper temperatures in clean containers, cabinets or serving carts.</p> <p>E. Milk.</p> <p>(1) Raw milk shall not be used.</p> <p>(2) Condensed, evaporated, or dried milk products that are nationally recognized may be employed as "additives" in cooked food preparation but shall not be substituted or served to residents in place of milk.</p> <p>F. Collateral requirements. Compliance with this rule does not relieve a facility from the responsibility of meeting more stringent municipal regulations, ordinances or other requirements of state or federal laws governing food service</p>	A 036		

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Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 2066	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 04/09/2015
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NAME OF PROVIDER OR SUPPLIER PONCE DE LEON	STREET ADDRESS, CITY, STATE, ZIP CODE 640 ALTA VISTA SANTA FE, NM 87505
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(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 049	<p>Continued From page 13</p> <p>locked against egress when the building is occupied.</p> <p>(1) Exit doors may be provided with a night latch, dead bolt, or security chain, provided these devices are operable from the inside, by any occupant, without the use of a key, tool, or any special knowledge and are mounted at a height not to exceed forty-eight (48) inches above the finished floor.</p> <p>(2) If locks are not readily operable by all occupants within the building, the locks must: 1) unlock upon activation of the fire detection or sprinkler system and 2) unlock upon loss of power in the facility. Prior to installing such locking devices, the facility shall have written approval from the building, fire and licensing authorities having jurisdiction.</p> <p>B. All exit doors shall have a minimum width of thirty-six (36) inches.</p> <p>(1) Facilities with a capacity of ten (10) or more residents shall have exit doors leading to the outside of the facility that open outward.</p> <p>(2) Facilities with a capacity of fifty (50) or more residents must provide panic hardware at the exit doors.</p> <p>(3) No door or path of travel to a means of egress shall be less than twenty-eight (28) inches wide.</p> <p>C. All resident sleeping room doors must be at least one and three-quarters (1 3/4) inch solid core construction.</p> <p>D. Bathroom doors may be twenty-four (24) inches wide. Facilities with four (4) or more residents shall have at least one bathroom for every eight (8) residents with a door clearance of thirty-six (36) inches for access by persons with disabilities.</p> <p>E. Locks on doors to toilet rooms and bathrooms shall be capable of release from the outside.</p> <p>F. All doors shall readily open from the inside.</p>	A 049		

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Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 2066	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 04/09/2015
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NAME OF PROVIDER OR SUPPLIER PONCE DE LEON	STREET ADDRESS, CITY, STATE, ZIP CODE 640 ALTA VISTA SANTA FE, NM 87506
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(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 049	<p>Continued From page 14</p> <p>G. Doors shall be provided for all resident sleeping rooms, all restrooms and all bathrooms. [7.8.2.49 NMAC - Rp, 7.8.2.50 NMAC, 01/15/2010]</p> <p>This REQUIREMENT is not met as evidenced by: Reference : NFPA 101-2000 Edition, 7.2.1.8.1 Self-Closing Devices. Based on observation and interview, the facility failed to ensure the doors connected to the fire alarm and closed circuit TV system were closed/ able to close when the fire alarm system was activated. This deficient practice has the potential to affect all 59 residents identified on the resident census list provided by the Health and Wellness Director (HWD) on 04/09/15. This deficient practice presents a risk that a fire or smoke may spread from one fire/smoke compartment to another fire/smoke compartment, or that residents may exit through the propped open doors unnoticed thus posing a risk for elopement. The findings are:</p> <p>A. On 04/09/15 at 9:15 am, during observation, the north east exit door to the loading dock, street and designated smoking area was propped open with a rock.</p> <p>B. On 04/09/15 at 9:30 am during interview with HWD when asked about the exit door being propped open, she replied "Maintenance puts a rock there when they are working out there, or when deliveries are coming in or other contractors are doing work. They know they're not supposed to do that but it's easier for them so they don't have to keep going to let people back in. There is a camera there in case a resident goes out."</p>	A 049 049		

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Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 2066	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 04/09/2015
NAME OF PROVIDER OR SUPPLIER BROOKDALE SANTA FE		STREET ADDRESS, CITY, STATE, ZIP CODE 640 ALTA VISTA 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 049	Continued From page 15 C. On 04/09/15 at 9:30 am during interview, the HWD confirmed that residents could pass through the propped opened door undetected because the alarm will not sound.	A 049 7.82.49 7.8250	Compliant 4/09/15 Associate smoking area moved To south side of building to limit Traffic through door Sign posted requesting all Vendors, move-ins and Others check in at front desk And use front entrance. All associates instructed to use Front entrance only Exhibit F	

Kevin J. M. D'Lee 7/4/15