

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 5882	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 10/19/2010
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NAME OF PROVIDER OR SUPPLIER CAMINO RETIREMENT APARTMENTS	STREET ADDRESS, CITY, STATE, ZIP CODE 12101 LOMAS NE ALBUQUERQUE, NM 87112
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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
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A 000	<p>Initial Comments</p> <p>A Complaint investigation was completed for intake #NM00027737 for NMAC 7.8.2 regulations governing Assisted Living facilities. The Complaint was Unsubstantiated for allegation of Neglect.</p>	A 000		
A 032	<p>7 NMAC 8.2.32 Reporting of Incidents</p> <p>REPORTING OF INCIDENTS: A. The facility shall insure that all suspected cases or known incidents of resident abuse, neglect or exploitation are reported in accordance with 7.1.13 NMAC. (1) The facility shall also report any incident or unusual occurrence which has or could threaten the health, safety, or welfare of the residents and staff to the licensing authority complaint hotline within twenty-four (24) hours or by the next business day, if it is a weekend or a holiday. (2) The facility shall not delay a report to the complaint hotline while an internal investigation is conducted. B. The facility is responsible for conducting and documenting the investigation of all incidents within five (5) business days and shall submit a copy of the investigation report to the licensing authority. A copy of the report and the documentation, including the date and time that it was submitted to the licensing authority, shall be maintained on file at the facility. The investigation shall include the following: (1) a narrative description of the incident; (2) the result of the facility's investigation shall be recorded on the state approved incident report form for the current year, pursuant to 7.1.13 NMAC; and (3) plans for further actions in response to the incident. [7.8.2.32 NMAC - Rp, 7.8.2.33 NMAC,</p>	A 032	<p><i>ES</i> <i>Scanned</i> <i>11-10-10</i></p> 	

Division of Health Improvement

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

G. Roth

TITLE

Executive Director

(X6) DATE

11-5-10

STATE FORM

6889

KNSW11

If continuation sheet 1 of 4

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A 032	Continued From page 1 01/15/2010] This REQUIREMENT is not met as evidenced by: Refer to 7.8.2.32(A)(1) - Reporting of Incidents The facility shall 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. Based on record reviews and interview, the facility failed to ensure that significant incidents were reported to the licensing authority as required for 1 of 1 sampled residents (#1). The findings are: A. Review of Complaint Intake #27737 received on 09/30/10 revealed that a female resident (#1) fell 10 feet, from a window, hitting a concrete wall on the way down and landed on her back. The incident report noted that this was the second instance in which the resident had climbed out the window eloping from the facility. B. Review of The Department of Health computerized incident database revealed no incidents had been reported by the facility for the months of December 2009, April 2010 or May 2010. C. On 10/13/10 at 3:12 pm, during an interview with the Executive Director, he acknowledged that neither the December 2009 elopement incident nor the April 2010 fall incident were reported to the licensing authority as required.	A 032	7 NMAC 8.2.32 REPORTING OF INCIDENTS 1. All incident reports shall be sent to DHI per regulation. Effective immediately, all incident reports that are faxed to DHI shall have a fax transmittal sheet showing proof of fax filed with the incident report. A memo has been sent to all staff informing them of the new procedure. 2. The Executive Director or designee shall assure compliance with this regulation and new procedure. Date of Completion is 11/05/10.

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A 070	Continued From page 2	A 070		
A 070	7 NMAC 8.2.70 Incorporated and Related Rules and Codes INCORPORATED AND RELATED RULES AND CODES: The facilities that are subject to this rule are also subject to other rules, codes and standards that may, from time to time, be amended. This includes the following: A. Health Facility Licensure Fees and Procedures, New Mexico Department of Health, 7.1.7 NMAC. B. Health Facility Sanctions and Civil Monetary Penalties, New Mexico Department of Health, 7.1.8 NMAC. C. Adjudicatory Hearings for Licensed Facilities, New Mexico Department of Health, 7.1.2 NMAC. D. Caregiver's Criminal History Screening Requirements, 7.1.9 NMAC. E. Employee Abuse Registry 7.1.12 NMAC. F. Incident Reporting, Intake Processing and Training Requirements 7.1.13 NMAC. [7.8.2.70 NMAC - N, 01/15/2010] This REQUIREMENT is not met as evidenced by: Refer to 7.8.2.32(A)(1) - Reporting of Incidents The facility shall 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. Refer also to NMAC 7.1.13.9 (A)(2)(b) - Incident Reporting, Intake, Processing and Training Requirements (Effective date February 28, 2006) - Incident Management System Training	A 070		

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A 070	<p>Continued From page 3</p> <p>Curriculum Requirements on incident policies and procedures, timely reporting, unexpected deaths and other reportable incidents. All community based service providers have a duty to report incidents to the department within a twenty four hour period including admission to a hospital or the provision of emergency services that results in medical care which is unanticipated.</p> <p>Based on record reviews and interview, the facility failed to ensure that significant incidents were reported to the licensing authority as required for 1 of 1 sampled residents (#1). The findings are:</p> <p>A. Review of Complaint Intake #27737 received on 09/30/10 revealed that a female resident (#1) fell 10 feet, from a window, hitting a concrete wall on the way down and landed on her back. The incident report noted that this was the second instance in which the resident had climbed out the window eloping from the facility.</p> <p>B. Review of The Department of Health computerized incident database revealed no incidents had been reported by the facility for the months of December 2009, April 2010 or May 2010.</p> <p>C. On 10/13/10 at 3:12 pm, during an interview with the Executive Director, he acknowledged that neither the December 2009 elopement incident nor the April 2010 fall incident were reported to the licensing authority as required.</p>	A 070	<p>7 NMAC 8.2.70 INCORPORATED AND RELATED RULES AND CODES</p> <p>1. All incident reports shall be sent to DHI per regulation. Effective immediately, all incident reports that are faxed to DHI shall have a fax transmittal sheet showing proof of fax filed with the incident report. A memo has been sent to all staff informing them of the new procedure. 2. The Executive Director or designee shall assure compliance with this regulation and new procedure. Date of Completion is 11/05/10.</p>