

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 5794	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - WOODMARK AT UPTOWN B. WING _____	(X3) DATE SURVEY COMPLETED 09/30/2009
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NAME OF PROVIDER OR SUPPLIER WOODMARK AT UPTOWN (THE)	STREET ADDRESS, CITY, STATE, ZIP CODE 7201 PROSPECT PLACE NE ALBUQUERQUE, NM 87110
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A 01	OPENING REMARKS Surveyor: 21700 The following deficiencies were cited as a result of an annual survey conducted on 09/30/09 for the Life Safety Code portion of the New Mexico Regulations Governing Requirements for Adult Residential Care Facilities 7.8.2 NMAC.	A 01	Submission of this Plan of Correction (POC) is not a legal admission that a deficiency exists, or that this State of Deficiency was correctly cited, and is also not to be construed as an admission against interest by the facility, or any employees, agents, or other individuals who draft or may be discussed in the response. Plan of Correction does not constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in this allegation by the survey agency.	
A51	<p>7 NMAC 8.2.51 Exits</p> <p>7.8.2.51 EXITS:</p> <p>A. Each facility must have at least two (2) approved exits, that do not involve windows and which are remote from each other. At least one path of travel shall be provided that does not traverse any space exposed to unprotected vertical openings or common living spaces.</p> <p>B. Facilities with ten (10) or more residents shall have each exit clearly marked with signs having letters at least six inches (6") high whose principal strokes are at least 3/4 of an inch wide. Exit signs shall be visible at all times.</p> <p>C. Exits must be clear of obstructions at all times.</p> <p>D. Exits, exit paths, or means of egress shall not pass through hazardous areas, storerooms, closets, bedrooms, or spaces subject to locking.</p> <p>E. Sliding doors are not acceptable as a required exit. EXCEPTION: Adult residential care facilities with three (3) or fewer residents may have sliding doors as required exits. [7-1-64, 9-15-70, 9-24-76, 7-11-86, 4-7-97; 7.8.2.51 NMAC - Rn, 7 NMAC 8.2.51, 8-31-00] This REQUIREMENT is not met as evidenced by: Surveyor: 21700 NFPA 101 2000 edition 7.7 DISCHARGE FROM EXITS Section 7.7.1*</p>	<p>A51</p> <p><i>ES Scanned 10-26-09</i></p>	<p>A51 7NMAC 8.2.51 Exits</p> <ol style="list-style-type: none"> 1. A level and hard surface will be installed from the 12 foot by 6 foot landing to a public way. The surface will be usable in all weather conditions by all occupants. 2. Maintenance Director will be responsible for keeping the surface cleared and usable in all weather conditions by all residents. 3. Employees will be in-serviced on use of the sidewalk during emergencies 4. Completion date: 10-30-09 	



Division of Health Improvement <i>Shaun R. Bingham</i> LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE <i>Executive Director</i>	(X6) DATE 10-13-09
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A51	Continued From page 1 Exits shall terminate directly at a public way or at an exterior exit discharge. Yards, courts, open spaces, or other portions of the exit discharge shall be of required width and size to provide all occupants with a safe access to a public way. Based on observation and staff interview, the facility failed to assure one (1) of two (2) required exits terminate directly at a public way. This deficient practice has the potential to affect all staff and residents within the Memory Care Unit. The facility is licensed for 144, and the census during the time of survey was 134. The findings are: On September 30, 2009 during a tour of the facility with the Environmental Services Director, the Life Safety Code Surveyor observed the following: 1. At 4:05 pm, the northeast exit discharge terminated at a 12' foot by 6' foot landing. The exit discharge did not have a level or hard surface from this point to a public way. The exit path was gravel, which would not be useable in all weather conditions or by all occupants. a. The Environmental Services Director acknowledged the concern and agreed to extend a sidewalk to the public way. b. This finding was acknowledged by the Administrator at the exit conference on 09/30/09.	A51		
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	A60		

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A60	Continued From page 2 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] This REQUIREMENT is not met as evidenced by: Surveyor: 21700 Based on observation, 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 144, and the census was 134. The findings are: On September 30, 2009, during a tour of the	A60	A60 7NMAC 89.2.60 Fire Alarms, Smoke Detectors and other Equip 1. A smoke detector will be installed in the tea room in the S.P.A. unit. 2. Maintenance Director will be responsible for maintaining and adding tea room smoke detector to regular preventative maintenance schedule along with other smoke detectors in the building. 3. Inform/in-service regarding installation of fire detector 4. Completion date: 10-30-09	

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A60	Continued From page 3 facility with the Environmental Services Director, the Life Safety Code Surveyor observed the following: 1. At 2:25 pm, the tea room was not equipped with smoke detection. a. During interview with the Environmental Services Director, it was explained that residents do use the tea room. b. The Administrator acknowledged this finding at the exit conference on 09/30/09.	A60		
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 least one (1) fire drill each month:	A63	A63 7NMAC 8.2.63 Staff and Resident Fire & Safety Training 1. Fire drills will be conducted quarterly at least once on every shift to ensure safety and preparedness of staff and residents. 2. Fire drills on all shifts will be completed within 90 days. 3. Maintenance Director will be responsible for ensuring the fire drills are completed as stated above. 4. Completion date 10-30-09	

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A63	<p>Continued From page 4</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 Reference D. Fire Drills:</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 134 and the licensed capacity was 144. The findings are:</p> <p>On September 30, 2009, during a review of facility records with the Environmental Services Director, the Life Safety Code Surveyor observed the following:</p>	A63		

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A63	Continued From page 5 1. During interview with the Environmental Services Director, it was stated that there are three (3) staff shifts per day as follows: Day shift from 6:30 am to 2:30 pm. Evening shift from 2:30 pm to 11 pm. Night shift from 11:00 pm to 7:00 am. a. There was no evidence of a fire drill for the evening shift (2:30 pm-11:00 pm) between the dates of 04/27/09 and 08/31/09. b. There was no evidence of a fire drill for the night shift (11:00 pm-7:00 am) between the dates of 08/27/08 and 01/29/09. c. The Administrator acknowledged this finding at the exit conference on 9/30/09.	A63		
A64	7 NMAC 8.2.64 Smoking 7.8.2.64 SMOKING: A. Smoking by residents and staff must only be done in supervised areas designated by the facility and approved by the State Fire Marshall or local fire prevention authorities. Smoking must not be allowed in a kitchen or food preparation areas. B. All designated smoking areas must be provided with suitable ashtrays. C. Residents must not be permitted to smoke in their sleeping rooms. D. Smoking must not be permitted where oxygen is in use or stored. [9-24-76, 7-11-86, 4-7-97; 7.8.2.64 NMAC - Rn, 7 NMAC 8.2.64, 8-31-00] This REQUIREMENT is not met as evidenced by: Surveyor: 21700	A64	A64 7NMAC8.2.64 Smoking 1. Five gallon bucket filled with sand has been removed from mechanical patio. 2. Staff No Smoking Policy has been implemented. 3. Staff will not smoke on The Woodmark at Uptown premises. Will be in-serviced 10-16-09. 4. Executive Director & Maintenance Director will be responsible for ensuring that staff follows policy. 5. Completion date 10-30-09	

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A64	<p>Continued From page 6</p> <p>Based on observation, the facility's practice failed to ensure that self-closing metal containers are provided for the disposal of cigarette butts. This deficient practice has the potential to affect all staff and residents throughout the facility. The licensed capacity of the facility is 144, and the census during the time of survey was 134. The findings are:</p> <p>On September 30, 2009, during a tour of the facility with the Environmental Services Director, the Life Safety Code Surveyor observed the following.</p> <p>1. At 3:40 pm, the designated smoking area located at the mechanical patio was not provided with an acceptable ash tray.</p> <p>a. There was a five gallon bucket filled with sand being used as an ash tray at the mechanical patio.</p> <p>b. The Administrator acknowledged this finding at the exit conference on 09/30/09.</p>	A64		
			COMPLETION DATE	0-30-09