

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROV DER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 5647	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R-C 12/06/2019
--	---	---	--

NAME OF PROVIDER OR SUPPLIER CAREFREE LIVING	STREET ADDRESS, CITY, STATE, ZIP CODE 10916 JUAN TABO PLACE 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 000}	Initial Comments The following deficiencies were cited during a Revisit/Follow-up survey completed on 12/06/19 for the State requirements of 7 NMAC 8.2, Regulations for Assisted Living Facilities.	{A 000}		
{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 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, 7.8.2.32 NMAC, 01/15/2010]	{A 032}		

Division of Health Improvement
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 5647	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R-C 12/06/2019
--	---	--	--

NAME OF PROVIDER OR SUPPLIER CAREFREE LIVING	STREET ADDRESS, CITY, STATE, ZIP CODE 10916 JUAN TABO PLACE 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 032}	<p>Continued From page 1</p> <p>This REQUIREMENT is not met as evidenced by: 7.8.2.32 A (1)</p> <p>This is an uncorrected citation from survey dated 9/05/19.</p> <p>7.1.13 INCIDENT REPORTING, INTAKE, PROCESSING AND TRAINING REQUIREMENTS</p> <p>Refer to 7.1.13.7 W. & 8 B. (2)</p> <p>W. " Reportable incident " means possible abuse, neglect, exploitation, injuries of unknown origin and other events including but not limited to falls which cause injury, unexpected death, elopement, medication error which causes or is likely to cause harm, failure to follow a doctor's order or an ISP, or any other incident which may evidence abuse, neglect, or exploitation.</p> <p>B. (2) Division incident report form and notification by licensed health care facilities: The licensed health care facility shall report incidents utilizing the division's incident report form consistent with the requirements of the division's incident management system guide and CMS regulations as applicable. The licensed health care facility shall ensure that all incident report forms alleging abuse, neglect, exploitation, injuries of unknown origin or other reportable incidents are submitted by a reporter with direct knowledge of an incident, are completed on the bureau's incident report form and received by the division within twenty-four (24) hours of an incident or allegation of an incident or the next</p>	{A 032}		

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROV DER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 5647	(X2) MULT PLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R-C 12/06/2019
--	---	---	--

NAME OF PROVIDER OR SUPPLIER CAREFREE LIVING	STREET ADDRESS, CITY, STATE, ZIP CODE 10916 JUAN TABO PLACE NE ALBUQUERQUE, NM 87111
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{A 032}	<p>Continued From page 2</p> <p>business day if the incident occurs on a weekend or a holiday. The licensed health care facility shall ensure that the reporter with the most direct knowledge of the incident assists with the preparation of the incident report form.</p> <p>Based on record review and interview, the facility failed to ensure that incidents of possible abuse or unusual occurrence were reported to the Licensing Authority within twenty-four (24) hours or the next business day if on a holiday or weekend. This deficient practice has the potential for all 48 (R #s 1-48) residents identified on the census provided by Executive Director (ED) on 12/06/19, to be at risk of harm, injury, and/or death, if there is no oversight by the Licensing Authority, because the facility failed to report these incidents within 24 hours or the next business day if a holiday or weekend. The findings are:</p> <p>A. Record review of R #4's internal incident report dated 11/21/19, revealed direct care staff (DCS) #1 stated that "R #4 was sitting by [REDACTED] regular table when R #3 kicked [REDACTED] making a skin tear. [REDACTED]"</p> <p>B. On 12/06/19 at 3:40 pm, during an interview with the ED, she confirmed that the facility had not reported R #4's incident report dated 11/21/19 to the Licensing Authority within 24 hours or the next business day if a holiday or weekend.</p>	{A 032}		