

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 2161	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 04/27/2022
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NAME OF PROVIDER OR SUPPLIER
BROOKDALE TRAMWAY RIDGE

STREET ADDRESS, CITY, STATE, ZIP CODE
**4910 TRAMWAY RIDGE DRIVE 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
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(A 000) Initial Comments

The following deficiencies were cited during a Revisit/Follow-up survey completed on [REDACTED] 22 for the state requirements of 7 NMAC 8.2, Regulations for Assisted Living.

(A 017) 7 NMAC 8.2.17 Staff Training

STAFF TRAINING:
 A. Training and orientation for each new employee and volunteer that provides direct care shall include a minimum of sixteen (16) hours of supervised training prior to providing unsupervised care for residents.
 B. Documentation of orientation and subsequent trainings shall be kept in the personnel file at the facility.
 C. Training shall be provided at orientation and at least twelve (12) hours annually, the orientation, training and proof of competency shall include:
 (1) fire safety and evacuation training;
 (2) first aid;
 (3) safe food handling practices (for persons involved in food preparation), to include:
 (a) instructions in proper storage;
 (b) preparation and serving of food;
 (c) safety in food handling;
 (d) appropriate personal hygiene; and
 (e) infectious and communicable disease control;
 (4) confidentiality of records and resident information;
 (5) infection control;
 (6) resident rights;
 (7) reporting requirements for abuse, neglect or exploitation in accordance with 7.1.13 NMAC;
 (8) smoking policy for staff, residents and visitors;
 (9) methods to provide quality resident care;
 (10) emergency procedures;
 (11) medication assistance, including the certificate of training for staff that assist with

(A 000)

The following plan of correction for Brookdale Tramway Ridge regarding the statement of deficiencies dated April 27th [REDACTED] 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 submitted as confirmation of our ongoing efforts to comply with statutory and regulator regulations. In this document, we have outlined specific actions in response to identified issues. We have not provided a detailed response to each allegation or finding nor have we identified mitigating factors. We remain committed to the delivery of quality healthcare services and will continue to make changes and improvement to satisfy that objective.

(A 017)

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

M. P. Rudman

TITLE

Executive Director

(X6) DATE

9/19/23

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{A017}	Continued From page 1 medication delivery; and (12) the proper way to implement a resident ISP for staff that assist with ISPs. D. If a facility provides transportation to residents, employees of the facility who drive vehicles and transport residents shall have training in transportation safety for the elderly and disabled, including safe vehicle operation. [7.8.2.17 NMAC - Rp, 7.8.2.17 NMAC, 01/15/2010] This REQUIREMENT is <u>not met</u> as evidenced by: 7.8.2.17 <u>A,B</u> This is a partial uncorrected deficiency for the survey dated [REDACTED] 20. Based on record review and interview, the facility failed to ensure that there was documentation that Direct Care Staff (DCS) received 16 hours of supervised training prior to providing unsupervised care to the residents. This deficient practice could likely result in all [REDACTED] residents identified on the census provided by the Administrator on [REDACTED] 22, to be at risk of harm or injury, if staff have not received training on the methods of providing care and services. The findings are: A. Record review of DCS #1's (hire date [REDACTED] 22) staff file revealed no documentation of receiving the sixteen (16) hours of supervised training before providing unsupervised care. B. Record review of DCS #2's (hire date [REDACTED] 2) staff file revealed no documentation of receiving the sixteen (16) hours of supervised training before providing unsupervised care.	{A017}		

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{A 017}	Continued From page 2 C. Record review of DCS #3's (hire date [REDACTED] 22) staff file revealed no documentation of receiving the sixteen (16) hours of supervised training before providing unsupervised care. D. On [REDACTED] 22 at 2:10 pm, during an interview with the Administrator, she confirmed that DCS #s 1-3 staff files contained no documentation of receiving/completing the 16 hours of supervised training.	{A 017}		
{A 025}	7 NMAC 8.2.25 Resident Evaluation RESIDENT EVALUATION: A. A resident evaluation shall be completed by an appropriate staff member within fifteen (15) days prior to admission to determine the level of assistance that is needed and if the level of services required by the resident can be met by the facility. B. The initial resident evaluation shall establish a baseline in the resident ' s functional status and thereafter assist with identifying resident changes. The resident evaluation shall be reviewed and updated at a minimum of every six (6) months or when there is a significant change in the resident ' s health status. C. The resident ' s evaluation shall be documented on a resident evaluation form and at a minimum include the following abilities, behaviors or status: (1) activities of daily living; (2) cognitive abilities; reasoning and perception; the ability to articulate thoughts, memory function or impairment, etc; (3) communication and hearing; ability to communicate needs and understand instructions, etc;	{A 025}	<ol style="list-style-type: none"> 1) Documentation of completing the 16 hours of supervised care will be kept in employee files. 2) Business office coordinator/designee will audit direct care staff personnel files to check for required documentation. The community will utilize a Brookdale orientation checklist and validate documentation in direct care staff personnel files for care staff. 3) The nurse/designee is responsible for compliance with this plan. 4) To assist with ongoing compliance the Executive Director/designee will audit 2 new hires per month for 6 months. 5) Completion date July 16th [REDACTED] 	

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{A 025}	Continued From page 3 (4) vision; (5) physical functioning and skeletal problems; (6) incontinence of bowel/bladder; (7) psychosocial well-being; (8) mood and behavior; (9) activity interests; (10) diagnoses; (11) health conditions; (12) nutritional status; (13) oral or dental status; (14) skin conditions; (15) medication use and level of assistance needed with medications; (16) special treatments and procedures or special medical needs such as hospice; and (17) safety needs/high risk behaviors; history of falls agitation, wandering, fire safety issues, etc. D. The resident evaluation shall include a history and physical examination and an evaluation report by a physician or a physician extender within six (6) months of admission. A resident shall have a medical evaluation by a physician or a physician extender at least annually. E. The resident evaluation shall be reviewed and if needed revised by a licensed practical nurse, registered nurse or physician extender at the time the individual service plan is reviewed, at a minimum of every six (6) months or when a significant change in health status occurs. [7.8.2.25 NMAC - Rp, 7.8.2.25 NMAC, 01/15/2010] This REQUIREMENT <u>is not met</u> as evidenced by: <u>7.8.2.25 A</u>	{A 025}			

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{A 025}	Continued From page 4 This is a partial uncorrected deficiency for survey dated [REDACTED]/20. Based on record review and interview, the facility failed to ensure for [REDACTED] residents whose Evaluations were reviewed for compliance that they were completed within 15 days prior to admission. This deficient practice could likely to result in the residents not receiving appropriate care/services upon admission if the Direct Care Staff (DCS) are not aware of what the resident's needs are. The findings are: A. Record review of R #2's Evaluation dated [REDACTED] 22, revealed that the evaluation was not completed within 15-days prior to admission on [REDACTED] B. Record review of R #3's Evaluation dated [REDACTED] /22, revealed that the evaluation was not completed within 15-days prior to admission on [REDACTED] C. On [REDACTED] /22 at 1:10 pm, during an interview with the Administrator, she confirmed that R #s 2 and 3 Evaluations were not completed within 15-days prior to admission.	(A 025)	1) Nurse will complete evaluation within 15 days prior to admission 2) If resident does not move in within the 15 days nurse will redo assessment 3) Health and Wellness Director/designee is responsible for this plan 4) Executive Director will monitor each new move in for assessment date completion before move in 5) Completion date [REDACTED] 2023	
{A 026}	7 NMAC 8.2.26 Individual Service Plan INDIVIDUAL SERVICE PLAN (ISP): An ISP shall be developed and implemented within ten (10) calendar days of admission for each resident residing in the facility. A. The ISP shall address those areas of need as identified in the resident evaluation and through staff observation. (1) The ISP shall detail the services that are provided by the facility as well as the services to	(A 026)		

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(A 026)	<p>Continued From page 5</p> <p>be provided by other agencies.</p> <p>(2) The resident evaluation and the ISP shall be reviewed and if needed revised by a licensed practical nurse, registered nurse or a physician extender.</p> <p>(3) The ISP shall be reviewed and or revised at a minimum of every six (6) months or when there is a significant change in the resident ' s health status.</p> <p>B. The ISP shall include the following:</p> <p>(1) a description of identified needs as noted in the resident evaluation;</p> <p>(2) a written description of all services to be provided;</p> <p>(3) who will provide the services;</p> <p>(4) when or how often the services will be provided;</p> <p>(5) how the services will be provided;</p> <p>(6) where the services will be provided;</p> <p>(7) expected goals and outcomes of the services;</p> <p>(8) documentation of the facility ' s determination that it is able to meet the needs of the resident;</p> <p>(9) the level of assistance that the resident will require with activities of daily living and with medications;</p> <p>(10) a crisis prevention/intervention plan when indicated by diagnosis or behavior; and</p> <p>(11) current orders for all medications, including those authorized for PRN usage.</p> <p>[7.8.2.26 NMAC - Rp, 7.8.2.26 NMAC, 01/15/2010]</p> <p>This REQUIREMENT is not met as evidenced by: 7.8.2.26</p> <p>This is a partial uncorrected deficiency for survey dated [REDACTED] 20.</p>	(A 026)		

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{A 026}	Continued From page 6 Based on record review and interview, the facility failed to ensure for [REDACTED] residents whose Individual Service Plans (ISPs) were reviewed for compliance, that they were completed within 10 days after admission to the facility. This deficient practice is likely to result in residents not receiving appropriate care/services if the Direct Care Staff (DCS) are not aware of what the resident's needs are. The findings are: A. Record review of R #1's Individual Service Plan (ISP) dated [REDACTED] 21, revealed that the ISP was not completed within 10-days after admission on [REDACTED] /21. B. Record review of R #2's Individual Service Plan (ISP) dated [REDACTED] 22, revealed that the ISP was not completed within 10-days after admission on [REDACTED] /22. C. Record review of R #3's Individual Service Plan (ISP) dated [REDACTED] 22, revealed that the ISP was not completed within 10-days after admission on [REDACTED] /22. D. On [REDACTED] /21 at 1:10 pm, during an interview with the Administrator, she confirmed that R #s 1-3s ISPs were not completed within 10-days after admission.	{A 026}	1) Health and Wellness Director will complete new admissions ISP within 10 days of move in 2) Executive Director will audit new move in files within 10 days of move in for 6 months to assure compliance. 3) Completion date [REDACTED]	
{A 042}	7 NMAC 8.2.42 Maintenance of Building and Grounds MAINTENANCE OF BUILDING AND GROUNDS: The building(s) shall be maintained in good repair at all times. Such maintenance shall include, but is not limited to, the following areas: A. Storage areas/grounds. Storage areas and	{A 042}		

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(A042)	<p>Continued From page 7</p> <p>grounds shall be maintained in a safe, sanitary and presentable condition at all times. Storage areas and grounds shall be kept free from accumulation of refuse, weeds, discarded furniture, old newspapers or other items that create a fire hazard.</p> <p>B. Floors. Floors shall be maintained stable, firm and free of tripping hazards. [7.8.2.42 NMAC - Rp, 7.8.2.43 NMAC, 01/15/2010]</p> <p>This REQUIREMENT is not met as evidenced by: 7.8.2.42 A</p> <p>This is a partial uncorrected deficiency for survey dated [REDACTED] 20.</p> <p>Based on observation and interview, the facility failed to ensure that the walls and ceilings were in good condition with no damage or drywall penetrations (holes). This deficient practice could likely result in all 8 (R #s 1-8) residents identified on the census provided by the Administrator on [REDACTED]/22, to be at risk of harm, injury, or death if a fire were to occur. The findings are:</p> <p>A. On [REDACTED]/22 at 9:46 am, during observation of the storage closet in the Southeast neighborhood, revealed a penetration (hole in the drywall) approximately 25" X 37" in the common wall between the dining room sink and storage room.</p> <p>B. On [REDACTED]/22 at 9:53 am, during observation of the electrical room in the main kitchen area of the 1-story memory care building revealed there was no drywall on the ceiling approximately 6' X 13' with exposed insulation, electrical conduit and pipes.</p>	(A042)	<ol style="list-style-type: none"> 1) All areas have been addressed and fixed. 2) Maintenance director to monitor for compliance that issues are addressed in a timely manner. 3) Completion date [REDACTED] 2023 	

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{A061}	<p>Continued From page 9</p> <p>remodeling or replacing existing smoke detectors shall provide detectors in common living areas and in each sleeping room.</p> <p>(3) Smoke detectors shall be installed in corridors at no more than thirty (30) foot spacing.</p> <p>(4) Heat detectors shall be installed in all kitchens and also powered by the house electrical service. [7.8.2.61 NMAC - Rp, 7.8.2.60 NMAC, 01/15/2010]</p> <p>This REQUIREMENT is not met as evidenced by: 7.8.2.61 B (3 & 4)</p> <p>This is an uncorrected deficiency from the survey dated [REDACTED] 20.</p> <p>Based on observation and interview, the facility failed to ensure that:</p> <ol style="list-style-type: none"> 1. A heat detector was installed in the kitchen area. 2. Smoke detectors were installed in corridors or main gathering areas. <p>This deficient practice could likely result in all [REDACTED] residents identified on the census provided by the Administrator on [REDACTED] 22, to be at risk of injury by fire/smoke if the smoke and heat detectors are not installed and a fire were to occur.</p> <p>A. On [REDACTED] 22 at 1:50 pm, during observation of the four (4) dining areas, no smoke detectors were observed to have been installed in any of these main gathering areas.</p> <p>B. On [REDACTED] 22 at 1:55 pm, during observation of the kitchen area (only dining area with a stove),</p>	{A061}	<p>1 Smoke detectors have been installed in dining areas</p> <p>2 Smoke detectors have been installed every 30 feet.</p> <p>3 heat detector installed in kitchen area</p> <p>4 Maintenance director and Executive Director responsible for compliance</p> <p>5 Maintenance Director will monitor for completion</p> <p>Completion date [REDACTED]</p>	

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{A 042}	<p>Continued From page 8</p> <p>C. On [REDACTED] 22 at 9:56 am, during observations in the Northwest neighborhood dining area revealed:</p> <ol style="list-style-type: none"> 1. A penetration (hole in the drywall) underneath the sink approximately 2' x 2'. 2. Water damage and mold on the wall underneath the sink. <p>D. On [REDACTED] 22 at 9:34 am, during observation of the Northeast kitchen/dining area (Western quarters) revealed a penetration (hole in the drywall) approximately 1' x 1' underneath the sink.</p> <p>E. On [REDACTED] 22 at 10:10 am, during an interview with the Administrator, she confirmed the observations/findings listed above in the Southeast, Northwest, and Northeast neighborhood areas and in the electrical room.</p>	{A 042}		
{A 061}	<p>7 NMAC 8.2.61 Fire Alarms, Smoke Detectors and Other Equip</p> <p>FIRE ALARMS, SMOKE DETECTORS AND OTHER EQUIPMENT:</p> <p>A. Fire alarm system. Facilities with four (4) or more residents shall have a manual fire alarm system. The manual fire alarm shall be inspected and approved in writing by the fire authority with jurisdiction.</p> <p>B. Smoke and heat detection. Approved smoke detectors shall be installed on each floor that when activated provides an alarm which is audible in all sleeping areas. Areas of assembly, such as the dining and living room(s) 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</p>	{A 061}		

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{A 061}	Continued From page 10 revealed it had no heat detector installed. C. On [REDACTED] 22 at 1:58 pm, during observation of the main corridor, revealed no smoke detectors were installed. The corridor was observed to be more than 30 feet in length. D. On [REDACTED] 22 at 2:00 pm, during interview with the Maintenance Manager, he confirmed that there were no smoke detectors in the main corridor (which exceeds 30 feet in length), no smoke detectors in any of the dining rooms, and no heat detector in the kitchen area.	{A 061}		
{A 062}	7 NMAC 8.2.62 Automatic Fire Protection (Sprinkler) System AUTOMATIC FIRE PROTECTION (SPRINKLER) SYSTEM: Facilities with nine (9) or more residents shall have an automatic fire protection (sprinkler) system. The system shall be in accordance with NFPA 13 or NFPA 13D or its subsequent replacement as applicable. [7.8.2.62 NMAC - Rp, 7.8.2.61 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.62 This is an uncorrected deficiency from the survey dated [REDACTED] 20. National Fire Protection Agency (NFPA) 13.6.2.7.1 Plates, escutcheons, or other devices used to cover annular space around a sprinkler shall be metallic or shall be listed for use around	{A 062}		

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{A 062}	<p>Continued From page 11</p> <p>a sprinkler.</p> <p>Based on observation and interview, the facility failed to ensure the automatic fire sprinkler system had the sprinkler heads maintained throughout the facility. This deficient practice of not maintaining the automatic sprinkler system, being unreliable for extinguishing fire and could likely result in the [REDACTED] residents identified on the census provided by the Administrator on [REDACTED] 22, and all building occupants to be at risk of harm, injury, or death, if a fire were to occur, because the sprinkler system did not work properly and there were perforations in the ceiling due to missing escutcheons causing the fire to spread more rapidly. The findings are:</p> <p>A. On [REDACTED] 22 at 9:00 am, during observation, the escutcheons (plate covers) around the sprinkler heads were missing, causing perforations in the ceiling or were in ill repair (hanging below the ceiling) in the Southeast quadrant dining room, in the office adjacent to the Southwest quadrant dining room, and in the kitchen.</p> <p>B. On [REDACTED] 22 at 10:10 am, during an interview with the Administrator, she confirmed the escutcheon were either missing or improperly fitted around multiple sprinkler heads located in the Southeast dining room, in the office adjacent to the Southwest dining room, and in the kitchen.</p>	{A 062}	<ol style="list-style-type: none"> 1) Smoke detectors have been installed in all areas. 2) Sprinklers all have escutcheons installed. 3) Maintenance Director will monitor for ongoing compliance. 4) Completion date [REDACTED] 2023 	