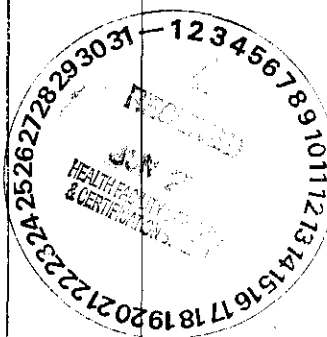


Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 2161	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - BROOKDALE PLACE OF ALBU B. WING _____	(X3) DATE SURVEY COMPLETED 05/11/2010
NAME OF PROVIDER OR SUPPLIER BROOKDALE PLACE OF ALBUQUERQUE #1		STREET ADDRESS, CITY, STATE, ZIP CODE 4900 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
A 003	7 NMAC 8.2.3 Statutory Authority STATUTORY AUTHORITY: The requirements set forth herein have been promulgated by the secretary of the New Mexico department of health, by authority of Section 9-7-6 of the Department of Health Act, NMSA 1978, as amended; and Sections 24-1-2, 24-1-3, 24-1-5 and 24-1-5.2 of the Public Health Act, NMSA 1978, as amended. [7.8.2.3 NMAC - Rp, 7.8.2.3 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: The following deficiencies were cited as a result of an annual survey conducted on May 11, 2010, for the Life Safety Code portion of the New Mexico Regulations Governing Requirements for Assisted Living Facilities 7.8.2 NMAC.	A 003	003. Responses to the cited deficiencies do not constitute an admission or an agreement by the facility of the truth of the facts alleged or conclusion set forth in the Statement of Deficiencies. The Plan of Correction is prepared solely as a matter of compliance with federal and/or state law.	
A 050	7 NMAC 8.2.50 Exits EXITS: A. The facility shall have at least two (2) approved exits, that do not involve windows and which are remote from each other. B. Facilities with ten (10) or more residents shall have each exit clearly marked with lighted signs having letters at least six (6) inches high and at least three-quarters (3/4) of an inch wide. Exit signs shall be visible at all times. C. Facilities with three (3) or fewer residents shall have a flashlight that is immediately available for use in lieu of electrically interconnected emergency lighting. D. Exits shall be clear of obstructions at all times. E. Exits, exit paths, or means of egress shall not pass through hazardous areas, garages, storerooms, closets, utility rooms, laundry rooms, bedrooms, or spaces subject to locking.	A 050	A 050. 7 NMAC 8.2.050 Exits 1. What steps will be taken to correct the situation. 1. All exit signs in question will be removed and replaced with exit signs that are illuminated at all times. This will be done by June 4, 2010. 2. Who will monitor for continued compliance. The maintenance tech will be responsible for checking exit signs for operating correctly during monthly preventive maintenance rounds. The ED will check exit signs for operation periodically as a backup.	5/14/10



Division of Health Improvement

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

Executive Director

TITLE

5/27/10

(X6) DATE

STATE FORM

6899

BVL421

If continuation sheet 1 of 6

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 2161	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - BROOKDALE PLACE OF ALBI B. WING _____	(X3) DATE SURVEY COMPLETED 05/11/2010
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A 050	Continued From page 1 F. For facilities with four (4) or more residents, sliding doors are not acceptable as a required exit. EXCEPTION: Assisted living facilities with three (3) or fewer residents may have sliding doors as required exits. G. When the yard gate(s) is part of the exit access and is locked, the gate shall be connected to the fire protection system and release upon activation of the fire/smoke system or shall have the ability to be unlocked at the gate site. [7.8.2.50 NMAC - Rp, 7.8.2.51 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure exits signs were readily visible and illuminated in both the normal and emergency mode to provide occupants clear direction of travel to the nearest exit in an event of an emergency. This deficient practice has the potential to affect all residents, staff and occupants of the facility. The facility is licensed for 40 residents, and the census during time of survey was 38 residents. The findings are: - On 05/11/10 at 2:00 pm, during a tour of the facility with the Maintenance Director, the surveyor observed the exit sign at the north exit failed to illuminate in both the normal and emergency mode. - At this time, the Maintenance Director stated, "I do not believe these exit signs are connected to the facility electrical system." - The Program Manager and Maintenance Director acknowledged the finding at the exit conference on 05/11/10 at 3:30 pm. - On 05/11/10 at 2:30 pm, during a tour of the	A 050		

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A 050	Continued From page 2 facility with the Maintenance Director, the surveyor observed the two (2) exit signs located at the front entrance failed to illuminate in both the normal and emergency mode. a. At this time, the Maintenance Director stated, "I do not believe these exit signs are connected to the facility electrical system." b. The Program Manager and Maintenance Director acknowledged the finding at the exit conference on 05/11/10 at 3:30 pm.	A 050		
A 061	7 NMAC 8.2.61 Fire Alarms, Smoke Detectors and Other Equip FIRE ALARMS, SMOKE DETECTORS AND OTHER EQUIPMENT: 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. 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. (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 shall be installed in corridors at no more than thirty (30) foot spacing. (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]	A 061		

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A 061	Continued From page 3 This REQUIREMENT is not met as evidenced by: Based on observation, the facility's practice failed to ensure that the fire alarm system and its components are easily accessible in accordance with NFPA 72 (National Fire Alarm Code) by keeping fire alarm pull stations and other components from being obstructed. This deficient practice has the potential to affect all residents and staff within the facility. The licensed capacity of the facility is 40 residents, and the census during the time of survey was 38 residents. The findings are: On 5/11/10 at 2:45 pm, during a tour of the facility with the Maintenance Director, the Life Safety Code Surveyor observed the following: 1. On 5/11/10 at 2:45 pm, the fire alarm pull station located at the south exit was obstructed by a chair. This fire alarm pull station was not easily accessible. a. The Program Manager and Maintenance Director acknowledged this finding at the exit conference on 05/11/10 at 3:30 pm. Based on observation and staff interview, the facility failed to ensure the fire alarm system and its components including batteries are maintained in accordance with NFPA 70 (National Electric Code) and NFPA 72 (National Fire Alarm Code). This deficient practice has the potential to affect all residents and staff throughout the facility. The licensed capacity of the facility is 40 residents,	A 061	A 061. 7 NMAC 8.2.061 Fire Alarms, Smoke Detectors and Other Equip 1. What steps will be taken to correct the situation. 1. On the day of survey, all obstructions in question were removed. 2. On 5/14/10, all six (6) batteries were replaced, signed, and dated by the Maintenance Tech. 2. Who will monitor for continued compliance. 1. The Maintenance Tech and the Clare Bridge Coordinator will be responsible for insuring compliance during daily rounds. 2. The Maintenance Tech will be responsible for inspecting the batteries for operation on a quarterly basis.	5/14/10

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A 061	Continued From page 4 and the census during the time of survey was 38 residents. The findings are: On 5/11/10 at 2:45 pm, during a tour of the facility with the Maintenance Director, the Life Safety Code Surveyor observed the following: 2. On 5/11/10 at 3:15 pm, the surveyor observed that six (6) batteries within the main fire alarm control panel have not been replaced since 6/08/06. a. The batteries manufacture's warranty was not available for review. Battery replacement is required every two years unless manufacture's warranty suggests something else. b. No further evidence was available for review indicating the suggested date of battery replacement. c. The Program Manager and Maintenance Director acknowledged this finding at the exit conference on 05/11/10 at 3:30 pm.	A 061			
A 065	7 NMAC 8.2.65 Fire Drills FIRE DRILLS: All facilities shall conduct monthly fire drills which are to be documented. A. There shall be at least one (1) documented fire drill per month and at a minimum, one documented fire drill each eight (8) hours (day, evening, night) per quarter that employs the use of the fire alarm system or the detector system in the facility. B. A record of the monthly fire drills shall be maintained on file in the facility and readily available. Fire drill records shall show: (1) the date of the drill; (2) the time of the drill; (3) the number of staff participating in the drill; (4) any problem noted during the drill; and	A 065			

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A 065	Continued From page 5 (5) the evacuation time in total minutes. C. If applicable, the local fire department may be requested to supervise and participate in fire drills. [7.8.2.65 NMAC - Rp, 7.8.2.63 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 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 has the potential to affect all staff and residents throughout the facility. The facility is licensed for 40 residents, and the census during the time of survey was 38 residents. The findings are: On May 11, 2010 between 1:00 pm and 2:00 pm, during review of records and documentation with the Maintenance Director, the surveyor observed the following: 1. During interview with the Maintenance Director, it was stated that there are three (3) shifts per day as follows: 1st. shift from 6:00 am to 2:00 pm. 2nd. shift from 2:00 pm to 10 pm. 3rd. shift from 10:00 pm to 6:00 am. a. There was no evidence of a drill for the 2nd. shift between the dates of 12/14/09 and 04/07/10. b. The Program Manager and Maintenance Director acknowledged this finding at the exit conference on 5/11/10 at 3:30 pm.	A 065	A 065. 7 NMAC 8.2.066 Fire Drills 1. What steps will be taken to correct the situation. 1.a. The Maintenance Tech will insure that all future fire drills will be conducted in a timely manner and recorded to insure compliance. 2. Who will monitor for continued compliance. 1.a. The Maintenance Tech is responsible for all fire drills in the community. The ED will receive a copy of all drills to further insure that drills are conducted in a timely manner.	5/26/10