

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROV DER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 2039	(X2) MULT PLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 10/05/2016
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NAME OF PROVIDER OR SUPPLIER SIERRA SPRINGS ASSISTED LIVING	STREET ADDRESS, CITY, STATE, ZIP CODE 503 LOS LENTES ROAD NE LOS LUNAS, NM 87031
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A 000	Initial Comments The following deficiencies were cited as a result of a complaint survey conducted on 10/05/16 for the state requirements of 7 NMAC 8.2, Regulations for Assisted Living. One complaint #NM00030063 was substantiated with deficiencies cited.	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	A 032		

Division of Health Improvement LABORATORY D RECTOR'S OR PROV DER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE 02/27/17
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A 032	<p>Continued From page 1</p> <p>incident. [7.8.2.32 NMAC - Rp, 7.8.2.32 NMAC, 01/15/2010]</p> <p>This REQUIREMENT is not met as evidenced by: 7.8.2.32 A (1) (2) B (1) (2) (3)</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		

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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 all incidents of unusual occurrence which has or could threaten the health, safety, or welfare of all residents, were reported to the Licensing Authority within 24 hours or the next business day if a weekend or holiday. That an internal investigation was conducted within 5 business days and submitted to the Licensing Authority. This deficient practice has the potential for 12 (R#'s 1-12) residents as identified on the census list provided by the Administrator on 10/03/16 to be at risk of not receiving needed medical care and services if incidents are not being reported as required. If the facility is not conducting internal investigations and submitting their findings to the Licensing Authority, then residents are at risk of continued suffering and/or further injury if there is no over site of the care and services the facility is providing. The findings are:</p> <p>A. On 10/04/16 at 11:20 am, during an interview with R#4, [REDACTED] stated that [REDACTED] had bed bugs and they were everywhere, the people came in several times to spray, and it was way back in this year (2016).</p> <p>B. On 10/05/16 at 10:00 am, during an interview with R#2, [REDACTED] stated that [REDACTED] had bed bugs back in the summer of this year (2016) [REDACTED] could see them on [REDACTED] clothes. The facility sprayed about four times.</p> <p>C. On 10/05/16 record review of incident reports</p>	A 032		

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A 032	Continued From page 3 for June 2016 for bed bug infestation revealed no documentation of the incident. D. On 10/05/16 at 2:00 pm, during an interview with the Administrator, she confirmed that facility did have bed bugs in June 2016, she did not report the incident to the licensing authorities, and she did not have the facility inspected to state the bed bug infestation is gone.	A 032		
A 063	7 NMAC 8.2.63 Fire Extinguishers FIRE EXTINGUISHERS: Fire extinguisher(s) must be located in the facility, as approved by the state fire marshal or the fire prevention authority with jurisdiction. A. Facilities must as a minimum have two (2) 2A10BC fire extinguishers: (1) one (1) extinguisher located in the kitchen or food preparation area; (2) one (1) extinguisher centrally located in the facility; (3) all fire extinguishers shall be inspected yearly and recharged as needed; all fire extinguishers must be tagged noting the date of the inspection; (4) the maximum distance between fire extinguishers shall be fifty (50) feet. B. Fire extinguishers, alarm systems, automatic detection equipment and other fire fighting equipment shall be properly maintained and inspected as recommended by the manufacturer, state fire marshal, or the local fire authority. [7.8.2.63 NMAC - Rp, 7.8.2.62 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.63 A (3) B	A 063		

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A 063	Continued From page 4 Based on observation and interview the facility failed to ensure that 5 of 5 fire extinguishers had been inspected annually and monthly to ensure proper working order in case of fire. This deficient practice has the potential for all 12 (R #s 1-12) residents on the census provided by the Administrator on 10/03/16, to be at risk of injury or death if there is a fire and the fire extinguishers does not work properly. The findings are: A. On 10/04/16 at 10:45, during observation all five (5) fire extinguishers had not been inspected since May 2015 by an authorized contractor and, not inspected monthly by staff since March 2016. B. On 10/04/16 at 10:45 am, during an interview with the Administrator she confirmed that the five (5) fire extinguishers had not been inspected since May 2015 by an authorized contractor and, not inspected monthly by staff since March 2016.	A 063		
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.	A 070		

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A 070	<p>Continued From page 5</p> <p>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]</p> <p>This REQUIREMENT is not met as evidenced by: 7.8.2.70 F</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</p>	A 070		

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A 070	<p>Continued From page 6</p> <p>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 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 all incidents of unusual occurrence which has or could threaten the health, safety, or welfare of all residents, were reported to the Licensing Authority within 24 hours or the next business day if a weekend or holiday. That an internal investigation was conducted within 5 business days and submitted to the Licensing Authority incident reporting compliance. This deficient practice has the potential for 12 (R#'s 1-12) residents identified on the census list provided by the Administrator on 10/03/16 to be at risk of not receiving needed medical care and services if incidents are not being reported as required. If the facility is not conducting internal investigations and submitting their findings to the Licensing Authority, then residents are at risk of continued suffering and/or further injury if there is no oversight of the care and services the facility is providing. The findings are:</p> <p>A. On 10/04/16 at 11:20 am, during an interview with R#4, [REDACTED] stated that [REDACTED] had bed bugs and they were everywhere, the people came in several times to spray, and it was way back in this year (2016).</p>	A 070		

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A 070	<p>Continued From page 7</p> <p>B. On 10/05/16 at 10:00 am, during an interview with R#2, [REDACTED] stated that [REDACTED] had bed bugs back in the summer of this year (2016) [REDACTED] could see them on [REDACTED] clothes. The facility sprayed about four times.</p> <p>C. On 10/05/16 record review of incident reports for June 2016 for bed bug infestation revealed no documentation of the incident.</p> <p>D. On 10/05/16 at 2:00 pm, during an interview with the Administrator, she confirmed that facility did have bed bugs in June 2016, she did not report the incident to the licensing authorities, and she did not have the facility inspected to state the bed bug infestation is gone.</p>	A 070		