STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROV DER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	4057	A. BUILDING: _____ B. WING _____	C 10/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELMCROFT OF QUINTESSENCE	7101 EUBANK BLVD NE ALBUQUERQUE, NM 87112

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG 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 Complaint survey completed on 10/22/19 for the state requirements of 7 NMAC 8.2, Regulations for Assisted Living. Complaint Intake #'s NM#39192 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		

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A 032	Continued From page 1 incident. [7.8.2.32 NMAC - Rp, 7.8.2.32 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.32. A (1) B (1) 7.1.13 INCIDENT REPORTING, INTAKE, PROCESSING AND TRAINING REQUIREMENTS Refer to 7.1.13.7 W. & 8 B. (2) 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. 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	A 032		

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A 032	Continued From page 2	A 032		

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.

Based on record review and interview, the facility failed to ensure that:

1. Incidents or injuries of unknown origin were reported to the Licensing Authority within twenty-four (24) hours or the next business day if a holiday or weekend.

2. A follow-up investigation report was submitted to the Licensing Authority within 5 business days from the date the incident occurred.

This deficient practice has the potential for all 56 (R #s 1-56) residents identified on the census provided by Residential Services Director (RSD) on 10/17/19, to be at risk of harm, injury, and/or death, if there is no oversight by the Licensing Authority, because the facility failed to:

1. Report injuries of unknown origin within 24 hours or the next business day if a holiday or weekend.

2. Submit follow-up investigation reports within 5 business days.

The findings are:

Related to not reporting incidents

A. Record review of the facility's internal incident reports revealed the following unwitnessed incidents with apparent injuries were not reported to the Licensing Authority with in twenty-four (24) hours or the next business day if the incident occurred on a weekend or a holiday:

1. Facility internal incident report dated

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A 032	Continued From page 3 [redacted]/19, Direct Care Staff (DCS #4) reported that R #7 was found in [redacted] bedroom on the floor with apparent injuries including [redacted] and was transported to hospital via ambulance for treatment. 2. Facility internal incident report dated [redacted]/19, DCS #1 reported that R #3 was found in [redacted] bedroom on the floor with apparent injuries including a [redacted] 3. Facility internal incident report dated [redacted]/19, DCS #5 reported that R #4 was found in [redacted] bedroom on the floor with apparent injuries [redacted] nd was taken to the via Emergency Medical Services (EMS) for treatment. 4. Facility internal incident report dated [redacted]/19, reported by DCS #4, reported R #5 was found in [redacted] bedroom on the floor with apparent injuries including [redacted] area and to the back of [redacted] and was taken to the hospital via ambulance for treatment. 5. Facility's internal incident report dated 08/09/19, reported by DCS #1 reported that R #6 was found in [redacted] bedroom on the floor with apparent injuries including [redacted] and was taken to the hospital via ambulance for treatment. 6. Facility internal incident report dated 08/07/19, reported by DCS #6 reported that R #7 was found in [redacted] bedroom on the floor with apparent injuries including [redacted] and was taken to the hospital via ambulance for treatment.	A 032		

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A 032	Continued From page 4 Findings related to 5-day investigation follow-up reports B. Record review of Complaint Intake #NM39192 revealed no documentation that a 5-day follow-up investigation report was submitted to the Licensing Authority regarding an incident involving R #1 on 08/20/19 whe [redacted]. R#1's [redacted] began Cardiopulmonary resuscitation (CPR) and was revived at the facility by Emergency Medical Technicians and transported to the hospital where [redacted] C. On 10/18/19 at 3:25 pm, during an interview with the RSD, she confirmed that: 1. The incidents of unwitnessed falls with injury listed above for R #s 3-7 were not reported to the Licensing Authority within twenty-four (24) hours or the next business day if the incident occurs on a weekend or a holiday. 2. There was no documentation that a 5-day investigation follow-up report was submitted to the Licensing Authority for the 08/20/19 incident when R #1 began [redacted] R#1's [redacted] began Cardiopulmonary resuscitation (CPR) and was revived at the facility by Emergency Medical Technicians and transported to the hospital where [redacted]	A 032		