

Division of Health Improvement

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROV DER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>2258</b> | (X2) MULT PLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____ | (X3) DATE SURVEY COMPLETED<br><br><b>C</b><br><b>10/03/2013</b> |
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| NAME OF PROVIDER OR SUPPLIER<br><br><b>WOODMARK AT UPTOWN (THE)</b> | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>7201 PROSPECT PLACE NE<br/>ALBUQUERQUE, NM 87110</b> |
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| A 000              | Initial Comments<br><br>A Complaint investigation was conducted for intake NM 00028933 on 10/03/13 for the state requirements of 7 NMAC 8.2 Regulations for Assisted Living.<br>The complaint was Substantiated with Deficiencies Cited.  | A 000         |   |                    |
| A 035              | 7 NMAC 8.2.35 Medication<br><br>MEDICATIONS: Administration of medications or staff assistance with self-administration of medications shall be in accordance with state and federal laws. No medications, including over-the-counter medications, PRN (when needed) medications, or treatment shall be started, changed or discontinued by the facility without an order from the physician, physician assistant or nurse practitioner and with entry into the resident's record.<br>A. State board of nursing licensed or certified health care professionals are responsible for the administration of medications. Administration may only be performed by these individuals.<br>B. Facility staff may assist a resident with the self-administration of medications if written consent by the resident is given to the administrator of the facility or the administrator ' s designee. If the resident is incapable of giving consent, the surrogate decision maker named in accordance with New Mexico law may give written consent for assistance with self-administration of medications. All staff that assist with self-administration of medications shall have successfully completed a state approved assistance with self-administration of medication training program or be licensed or certified by the state board of nursing.<br>C. PRN (pro re nada) medication.<br>(1) Physician or physician extender ' s orders for | A 035         |   |                    |

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| A 035              | <p>Continued From page 1</p> <p>PRN medications shall clearly indicate the circumstances in which they are to be used, the number of doses that may be given in a 24-hour period and indicate under what circumstances the primary care practitioner (PCP) is to be notified.</p> <p>(2) The utilization of PRN medications shall be reviewed routinely. Frequent or escalating use of PRN medications shall be reported to the PCP.</p> <p>D. Only a licensed nurse (RN or LPN) shall administer any medications or conduct any invasive procedures provided by the following routes: intravenous (IV), subcutaneous (SQ), intramuscular (IM), vaginal or rectal. Only a licensed nurse shall administer non-premixed nebulizer treatments.</p> <p>E. The facility shall have medication reference material that contains information relating to drug interactions and side effects on the premises. Staff that assist in the self-administration of medications shall know interactions or possible side effects that might occur.</p> <p>F. Medications prescribed for one resident shall not be used for another resident.</p> <p>G. Medication assistance record (MAR). For residents who are not independent and require assistance with self administration, the facility shall have a MAR that documents the details of the residents' medication, including PRN and over-the-counter medication that is assisted with self-administration by qualified staff or administered to the resident by licensed or certified staff. The information in the MAR shall include:</p> <p>(1) the resident's name;</p> <p>(2) any known allergies to medication that the resident has;</p> <p>(3) the name of the resident's PCP or the prescriber of the medication;</p> <p>(4) the diagnosis or reason for the medication;</p> | A 035         |   |                    |

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| A 035              | <p>Continued From page 2</p> <p>(5) the name of the medication, including the drug product brand name and the generic name;<br/>                     (6) notation if the medication is a schedule II-IV drug;<br/>                     (7) the dosage of the medication;<br/>                     (8) the strength of the medication;<br/>                     (9) the frequency or how often the medication is to be taken or given;<br/>                     (10) the route of delivery for the medication (mouth, eye, ear, other);<br/>                     (11) the method of delivery for the medication (pills, drops, IM injection, other);<br/>                     (12) the date that the medication was started or discontinued;<br/>                     (13) any change in the medication order;<br/>                     (14) pre-medication information (i.e., pulse, respiration, blood pressure, blood sugar) as required by the medication order;<br/>                     (15) the date and time that the medication is self-administered, administered with assistance or is administered;<br/>                     (16) the initials and signature of the person assisting with or administering the medication;<br/>                     (17) the desired results obtained from or problems encountered with the medication (pain relieved, allergic reaction, etc.);<br/>                     (18) any refused dose of medication;<br/>                     (19) any missed dose of medication; and<br/>                     (20) any medication error.</p> <p>H. No medication shall be stopped or started without specific orders from the primary care physician.</p> <p>I. If a resident refuses to take a prescribed medication, it shall be documented and the facility shall report it to the prescriber.</p> <p>J. A suspected adverse reaction to a medication shall be documented on the MAR and reported immediately to the PCP and the resident's surrogate decision maker. If applicable,</p> | A 035         |   |                    |

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| A 035              | <p>Continued From page 3</p> <p>emergency medical treatment shall be arranged. Documentation of the event shall be kept in the resident's record.</p> <p>K. Prescription medication, other than blister packs and unit dose containers, shall be kept in the original container with a pharmacy label that includes the following:</p> <ol style="list-style-type: none"> <li>(1) the resident's name;</li> <li>(2) the name of the medication;</li> <li>(3) the date that the prescription was issued;</li> <li>(4) the prescribed dosage and the instructions for administration of the medication; and</li> <li>(5) the name and title of the prescriber.</li> </ol> <p>L. Any medication that is removed from the pharmacy container or blister pack shall be given immediately and documented by the staff that assisted with the medication delivery.</p> <p>M. The facility shall report all medication errors to the physician, documentation of medication errors and the prescriber's response shall be kept in the resident's record.</p> <p>N. The facility shall develop and follow a written policy for unused, outdated, or recalled medications kept in the facility in accordance with 16.19.11.10 NMAC (AS AMENDED). [7.8.2.35 NMAC - Rp, 7.8.2.35 NMAC, 01/15/2010]</p> <p>This REQUIREMENT is not met as evidenced by:<br/>Refer to NMAC 7.8.2. 35 Section H ...No medication can be stopped by the facility without specific orders from the physician.</p> <p>Based on record review and interview, the facility failed to ensure that 1 resident (R #1) (who no longer resides at the facility) of 4 sampled</p> | A 035         |   |                    |

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| A 035              | <p>Continued From page 4</p> <p>residents (R #s 1, 2, 3, and 4 received medications as ordered by the physician. This deficient practice caused one resident (R #1) not to receive medications ordered by the physician. The findings are:</p> <p>A. Record Review for R #1 revealed the following:</p> <ol style="list-style-type: none"> <li>1. Complaint # NM 28933 Intake information indicated that R #1 did not receive medications as ordered.</li> <li>2. Physicians Orders dated [REDACTED]/2012 indicated: [REDACTED]</li> <li>3. The [REDACTED] 2013 MAR indicated that the staff missed 14 opportunities to administer [REDACTED]<br/>[REDACTED]<br/>[REDACTED]<br/>[REDACTED]<br/>[REDACTED]<br/>[REDACTED]<br/>[REDACTED]<br/>[REDACTED]<br/>[REDACTED]<br/>[REDACTED]</li> <li>4. There were circles on the MAR around staff initials on 02/06/13, 02/07/13, 02/08/13, 02/09/13, 02/10/13 and 02/11/13 indicated that the medications were not administered.</li> <li>5. There was no documentation to indicate that the medication was re-ordered from the pharmacy.</li> <li>6. The Drugs Received Sheet from the</li> </ol> | A 035        |   |                    |

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| A 035              | <p>Continued From page 5</p> <p>pharmacy indicated that the Quetiapine was not received until 02/11/13.</p> <p>B. On 10/03/13, interviews for R #1 revealed the following:</p> <ol style="list-style-type: none"> <li>1. At 11:30 am, when asked what the circles around the initials meant, the Director of Clinical Services stated, "That means it wasn't given." When asked what 'N/A' meant in the identified space on the back of the MAR, she stated, "That means it's not available."</li> <li>2. At 1:30 pm, Staff #1 implied that the pharmacy does not always deliver medications in a timely manner by stating "We have to constantly be on top of [Name of Pharmacy] for meds."</li> <li>3. At 1:50 pm, Staff #2 implied that the pharmacy does not always deliver medications in a timely manner by stating "We always have problems with [Name of pharmacy]."</li> <li>4. At 2:00 pm, Staff #3 stated "Sometimes we don't have all of the meds. [Name of pharmacy] is really bad about getting us the meds."</li> <li>5. At 4:30 pm, the resident's Case Manager (Complainant) stated, "When [redacted] would ask for medications, they would tell [redacted] to go to [redacted] room and wait or they just didn't give them to [redacted] I moved [redacted] out of there after I found out they weren't giving [redacted] meds."</li> </ol> <p>Refer to NMAC 7.8.2. 35 Section G 19 - Medication Assistance Record (MAR)...The information on the MAR shall include any missed dose of medication.</p> <p>Based on Record Review and Interview, the facility failed to document missed doses on the</p> | A 035        |   |                    |

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| A 035              | <p>Continued From page 6</p> <p>back of the MAR for 1 resident (R #1 who no longer resides at the facility) of 4 sampled residents (R #s 1, 2, 3, and 4). This deficient practice likely prevented medications from being ordered from pharmacy in a timely manner for R #1. The findings are:</p> <p>A. Review of the [REDACTED] 2013 MAR for R #1 indicated that the staff missed 14 opportunities to administer [REDACTED]</p> <p>B. There was documentation on the back of the MAR indicating the the [REDACTED] was not available on 02/06/13 (evening dose), 02/08/13 (morning, noon and evening dose), 02/09/13 (morning, noon and evening dose), 02/10/13 (morning, noon and evening dose), 02/11/13 (morning and noon).</p> <p>C. On 01/03/13 at 11:30 am, the Director of Clinical Services implied that missed doses of medication should be written on the back of the MAR with the reason why the medication was not given. When asked what 'N/A' meant in the identified space on the back of the MAR, she stated "That means it's not available."</p> <p>Refer to NMAC 7.8.2. Section B - Facility Staff May assist a resident with the self administration of medication... Section D - Only a licensed nurse (RN/LPN) shall administer medication...</p> <p>Based on record review, observation and interviews, the facility failed to ensure that Staff Members who were trained to assist resident with medications (meds) were assisting 3 residents (R</p> | A 035        |   |                    |

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| A 035              | <p>Continued From page 7</p> <p>#s 2, 3, and 4) of 4 sampled residents (R #s 1, 2, 3 and 4) with their medications instead of administering medications. This deficient practice is likely to result in medication errors and prevent residents from knowing what medications they are receiving. The findings are:</p> <p>A. On 10/03/13 during observation of Staff #1 and Staff #2 were "assisting" the residents with the morning medications, it was determined that the Staff were "administering" medications instead of assisting with meds as identified below:</p> <ol style="list-style-type: none"> <li>1. At 8:25 am, Staff #1 pulled the meds for R #2 from the med cart which was located in the medication prep room on the first floor. She popped 5 oral medications (pills and capsules) from a blister pack into a solo cup. Staff #1 then took the elevator to the 3rd floor, knocked on R #2's front door and stated, "I've got your pills." R #2 took the med cup and put the pills in [redacted] mouth and swallowed them with water.</li> <li>2. At 8:38 am, Staff #1 retrieved the meds for R #3 from the same med cart. She popped 8 oral medications (pills and capsules) into a solo cup and obtained a container of nasal spray. She walked over to the the resident who was sitting in a chair in the med prep room and gave the cup which contained the oral medications to the resident as she stated, "Here's your pills." R #3 took the med cup and put the pills in [redacted] mouth and swallowed them with water. Staff #1 then gave the nasal spray to R #3 and the resident inhaled one spray in each nostril.</li> <li>3. At 8:50 am, Staff #2 retrieved the meds for R #4 from a different med cart. She popped 4 oral medications (pills and capsules) into a solo cup and 2 inhalers. She walked over to the the resident who was sitting in a chair in the med prep room and gave [redacted] the inhalers and spoke to [redacted] in Spanish. R #4 inhaled 2 puffs of one</li> </ol> | A 035        |   |                    |

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| A 035              | <p>Continued From page 8</p> <p>inhaler and 1 puff of a second inhaler. Staff #2 then gave the cup which contained the oral meds to the resident. She did not say anything to the resident when she gave [REDACTED] the cup. R #3 took the med cup and put the pills in [REDACTED] mouth and swallowed them with water.</p> <p>C. On 10/03/13, interviews revealed the following:</p> <ol style="list-style-type: none"> <li>At 8:45 am, the Executive Director indicated that there are 15 -20 staff working at the facility who assist residents with their medications. He stated, "We employ about 15 -20 'Med Techs' [A title used by the facility for staff that assist with medications]. They administer medications. We have a Clinical Director who is a RN [Registered Nurse] and she oversees everything."</li> <li>At 2:30 pm, the Clinical Director did not seem to have a clear understanding of administering medications and assisting with medications. She stated, "We use the Assisting With Medications...The Right Way for Licensed Adult Residential Care Facilities from The New Mexico Health Care Association. "The 'Med Techs' [A title used by the facility for staff that assist with medications] are not to give invasive meds. They give oral meds, eye drops and nasal sprays. The don't explain to the resident [what meds they are getting and why] every single time but if the resident ask, they [staff assisting with meds] tell them." When asked to explain the difference between administering and assisting with meds, she stated, "A nurse has full responsibility for the medications including information regarding the med, taking orders and filling meds. Assisting means having limited knowledge of the med and working under the supervision of a nurse. I guess I need to look that up in the regulations."</li> </ol> | A 035        |   |                    |

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| A 035              | <p>Continued From page 9</p> <p>C. Review of the "Assisting With Medications...The Right Way for Licensed Adult Residential Care Facilities produced by The New Mexico Health Care Association, 1st Edition - April 1999 Student Manual provided by the Clinical Director indicated that the facility did not follow the training guide the facility used to train their staff on assisting with medications.</p> <p>D. The training guide "Assisting With Medications...The Right Way for Licensed Adult Residential Care Facilities." indicated:</p> <ol style="list-style-type: none"> <li>1. "The intent of this training program is to prepare staff in licensed adult residential care facilities to assist residents with medication self administration"</li> <li>2. "As a part of your job you may be asked to help resident take their prescription and non prescription medications." (Page 1)</li> <li>3. "Only a licensed nurse can administer medications but you can help a resident take medications if they need help." (Page 3)</li> <li>4. ..."Leave the medication in their packages until you are ready to help the resident take the medication." (page 3)</li> <li>5. "Helping residents take medications, including taking the medication out of the storage unit, verifying it is the right medication in the right amount for the right resident, taking it to them, making sure the resident is the person you think he or she is, helping them take the medication if they need help or watching them take it if they don't." (Page 47)</li> </ol> <p>Refer to NMAC 7.8.2. section 35 L...Any medication that is removed from the pharmacy</p> | A 035         |   |                    |

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| NAME OF PROVIDER OR SUPPLIER<br><br><b>WOODMARK AT UPTOWN (THE)</b> | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>7201 PROSPECT PLACE NE<br/>ALBUQUERQUE, NM 87110</b> |
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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)   | D PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|--------------------|--|--------------|---|--------------------|
| A 035              | <p>Continued From page 10</p> <p>container or blister pack shall be given immediately and documented by the staff that assisted with the medication delivery.</p> <p>Based on record review, observation and interview, the facility failed to ensure that medications removed from the blister pack were given immediately for 1 resident (R #4) of 4 sampled residents (R #s 1, 2, 3 and 4). This deficient practice has the potential to affect 122 residents receiving medications. The findings are:</p> <p>A. Review of the October 2013 Medication Administration Record (MAR) for R #4 indicated [REDACTED]</p> <p>B. Observations revealed the following:</p> <ol style="list-style-type: none"> <li>1. On 10/03/13 at 8:50 am, Med Tech #2 popped out two [REDACTED] from R #4's blister pack.</li> <li>2. Med Tech #2 popped one tablet into her hands and one into solo med cup with the other pills. She then placed the pill from her hands into the pill cutter and cut it in half. She placed half (20 mg) of it into the solo cup where she had poured all of the other medications and placed the other half back into the blister pack and then placed scotch tape over the back of the bubble to hold the half pill in place.</li> </ol> <p>C. On 10/03/13 at 9:00 am, Med Tech #2 acknowledged that she had placed half of the pill back in the bubble pack and that she was not wearing gloves while handling the medications by shaking her head. She did not comment.</p> <p>D. Assisting With Medications...The Right Way for Licensed Adult Residential Care Facilities produced by The New Mexico Health Care Association, 1st Edition - April 1999 Student</p> | A 035        |   |                    |

Division of Health Improvement

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>2258</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____ | (X3) DATE SURVEY COMPLETED<br><br><b>C</b><br><b>10/03/2013</b> |
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|--------------------|--|---------------|---|--------------------|
| A 035              | Continued From page 11<br><br>Manual indicated "You cannot touch the medications with your hands." (Page 5)            | A 035         |   |                    |