

Division of Health Improvement

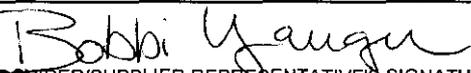
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION <h1 style="margin:0;">ORIGINAL</h1>	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>5796</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>04/23/2009</b>
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NAME OF PROVIDER OR SUPPLIER  <b>KINGSTON RESIDENCE OF SANTA FE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>2400 LEGACY COURT SANTA FE, NM 87505</b>
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A35	7 NMAC 8.2.35 Custodial Drug Permit  7.8.2.35 CUSTODIAL DRUG PERMIT: Any facility licensed pursuant to these regulations who supervises the administration, self-administration, or safeguards medications for residents, must have a current custodial drug permit issued by the State Board of Pharmacy. EXCEPTION: Adult residential care facilities with one (1) resident are not required to have a custodial drug permit. A. PROCUREMENT, LABELING, AND STORAGE: The facility shall provide assistance to the resident in obtaining the necessary medications, treatment and medical supplies as required by the individual or specified by the individual's health care plan. The facility shall procure, label, and store medications for residents in a manner which shall be in compliance with state and federal laws. (1) All medications, including non-prescription drugs, will be stored in a locked compartment or in a locked room, as approved by the Board of Pharmacy, and the key will be in the care of the director or designee. (2) Internal medication must be kept separate from external medications. Drugs to be taken by mouth will be separated from all other dosage forms. (3) A separate locked compartment will be available in the refrigerator for those items labeled "keep in refrigerator." The refrigerator temperature will be kept between thirty-five (35) and forty-five (45) degrees Fahrenheit. A thermometer is required to be kept in the refrigerator. (4) All medications, including non-prescription medications, must be stored in separate compartments for each resident and all medications will be labeled with the residents' names.	A35	<div style="text-align: center;">  </div>	
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Scanned 5/7/09 CR

Division of Health Improvement  LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE <i>Exec. Dir.</i>	(X6) DATE <b>05-06-09</b>
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A35	Continued From page 1  (5) A resident may be permitted to keep his/her own medication in a secure place in his/her room for self-administration if the physician's report has deemed it appropriate that the resident do so. (6) The facility may not require the resident to purchase prescriptions from any particular pharmacy. (7) Medical gases (oxygen) and equipment used for the administration of inhalation therapy and for resuscitative purposes must comply with National Fire Protection Association (NFPA) 99. B. CONSULTING PHARMACIST: The facility shall maintain records demonstrating the consulting pharmacist provides the following: (1) Reviews the medication regimen as needed, but at least quarterly (every three (3) months), to determine that all medications and records are accurate and current. All irregularities must be reported to the Director of the facility and these irregularities must be acted upon. (2) A system of records of receipt and disposition of all drugs in sufficient detail to enable an accurate reconciliation. (3) Consultation is provided on all aspects of pharmacy services in the facility, including reference information regarding side effects and, when needed, physician consultation in cases involving the use of psychotropic medications. [7-1-64, 9-15-70, 7-19-74, 9-24-76, 7-11-86, 1-11-90, 4-7-97; 7.8.2.35 NMAC - Rn, 7 NMAC 8.2.35, 8-31-00]  This REQUIREMENT is not met as evidenced by: Refer to NMAC 7.8.2.35(A)(1) - Drug Storage	A35		

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A35	Continued From page 2  Based on observation and interview, the facility failed to ensure that medications were stored under locked conditions. The findings are:  A. On 4/21/09 at 6:50 AM - 7:00 AM during a facility tour, it was noted that the facility medication cart for the AV#1 wing was unlocked and unattended. This cart was observed to have 4 drawers full of various medications for various residents of that wing. The medication cart was located to an adjacent exit door and in a pathway leading out the front door.  B. On 4/21/09 at 7:00 AM during interview with licensed nurse #1, she reported that the nursing staff are in charge of keys to the medication carts. She confirmed that the cart had been unlocked and open since about 5:00 AM that morning and that she was in charge of the keys to the cart.	A35	<u><b>A35</b></u>  <b>1) Immediate Correction</b> a) Licensed Nurse #1 was given verbal counseling on 4/23/09 as to the importance on checking the status on the medication cart and the necessity of keeping all medications in a secured location. Nurse #1 voiced her understanding. b) Educational material will be given and reviewed with all staff with access and responsibility to lock medication carts by 5/08/09	
A36	7 NMAC 8.2.36 Medications  7.8.2.36 MEDICATIONS: Medications will be administered or staff assistance with medications provided and documented in accordance with state and federal laws. A. Licensed health care professionals are responsible for the administration of medications. B. Facility staff may assist a resident with medications if written consent by the resident is given to the director of the facility or their designee. If the resident is incapable of giving consent, the resident's guardian, treatment guardian or surrogate decision maker named in accordance with New Mexico law may give written consent for the assistance with medications. All staff assisting with medications shall have successfully completed an approved assistance with medication training program or be	A36	<b>2) Potential to Affect</b> a) The deficit has the potential to directly affect all residents. Especially those with dementia and cognitive impairment.	

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A36	Continued From page 3  licensed by the State of New Mexico to administer medications. C. 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 by the physician and entry into the resident's record. D. The facility must have on the premises, medication reference material that contains information relating to drug interactions and side-effects. E. Medications prescribed for one resident shall not be used for another resident. F. The facility shall have a Medication Administration Record (MAR) documenting medications administered to residents, including over-the-counter medications. This documentation shall include: (1) Name of resident. (2) Date started. (3) Drug product name. (4) Dosage and form. (5) Strength of drug. (6) Route of administration (e.g. "by mouth"). (7) How often medication is to be taken. (8) Time taken and staff initials. (9) Dates when the medication is discontinued or changed. (10) The name and initials of all staff administering medications. G. Any medications removed from the pharmacy container or blister pack must be given immediately and documented by the person assisting. H. PRN Medications: The use of PRN medications must be closely monitored and supervised by the facility and is based on one or more of the following conditions:	A36	<b>3) Monitor Corrective Action</b> a) Medication Carts will be checked daily by Director of Nursing and Resident Care Coordinator at varying times for the next 30 days and weekly thereafter. Any further violations of the locked medication cart policy will have corrective actions on an individual staff performance level.	5/08/09

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A36	<p>Continued From page 4</p> <p>(1) The resident is capable of determining when the medication is needed.</p> <p>(2) The resident's physician has provided detailed instructions to the pharmacy regarding the administering of the medication. The physicians instruction for a PRN medication shall include:</p> <p>(a) Symptoms that might indicate the use of the medication.</p> <p>(b) Exact dosage to be used.</p> <p>(c) The exact amount of medication to be used in a 24 hour period.</p> <p>(d) Directions as to what to do if the symptoms persist.</p> <p>(e) Possible interactions or side-effects that might occur.</p> <p>(f) Manufacturer's label information for directions if deemed adequate by the physician.</p> <p>I. The facility must report all medication errors to the physician.</p> <p>J. The facility shall develop and follow a written policy for unused, outdated, or recalled medications being kept in the facility. [7-1-64, 9-15-70, 7019074, 9-24-76, 7-11-86, 1-11-90, 4-7-97; 7.8.2.36 NMAC - Rn, 7 NMAC 8.2.36, 8-31-00]</p> <p>This REQUIREMENT is not met as evidenced by: Refer to 7.8.2.36 - Staff assistance with medication, provided and documented in accordance with state and federal laws.</p> <p>Based on observations, the facility failed to ensure that staff charged with assisting residents with their medications, did so in accordance with professional standards and techniques for 1 of 4 staff trained to assist with medications (Staff #3). The findings are:</p> <p>A. On 4/21/09 at 7:20 - 7:45 AM during</p>	A36		

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A36	Continued From page 5  observation of the medication pass conducted by a staff person trained to assist with medications (Staff #3), the following was noted to happen in sequential order: -Staff #3 opened the medication cart with the key -Staff #3 began to pour Aspirin 81 mg for (Resident #24) out of a pill bottle into the cap. During the pour, 2 pills came out; 1 Aspirin was put in a souffle cup the other one was picked up by hand and put back into the Aspirin bottle. -Staff #3 did not sanitize hands before she began to pour the five (5) other medications for Resident #24's morning medications. Also, during this time, Staff #3 did not reflect upon the Medication Administration Record (MAR) to verify that no changes in Resident #24's medications had occurred since the last pass nor to verify dose and correctness of the medications being passed during the pour. Staff #24 proceeded to sign MAR quickly for all medications given -Staff #3 proceeded to pass the medications to Resident #24 -At 7:34 AM Staff #3 proceeded to the next Resident, Resident #23. Staff #3 knocked on her door to verify her presence, picked up the newspaper, touched the door handle opened the door prior to returning to the medication cart. Staff #3 stated that she would come back to do the meds for Resident #23 -Staff #3 did not sanitize her bare hands prior to starting the pour of Resident #22's eight (8) medications and medicated inhaler. Staff #3 proceeded to sign MAR quickly for all medications given. -Staff #3 proceeded to pass the medications to Resident #22 -Staff #3 did not sanitize her bare hands prior to starting the pour of Resident #20's three (3) medications --Staff #3 proceeded to pour three (3)	A36	<b><u>A36</u></b>  <b>1) Immediate Correction</b> a) Medication Technician / Staff #3 was verbally counseled as to the 5 rights of medication administration, infection control and proper technique with medication administration on 4/22/09. b) Staff #3 was placed on a 90 probationary period while retraining, retesting and reevaluation of her competency to provide services as a Medication Technician. c) Shadowing of Staff #3's medication assistance will occur daily for the next two weeks while written educational material is provided for Staff #3 to study.	

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A36	<p>Continued From page 6</p> <p>medications for Resident #20. During this pour, a Hydrocodone (narcotic pain) pill was over poured. One (1) Hydrocodone was put in a souffle cup the other one was picked up by hand and put back into the prescription bottle.</p> <p>-Staff #3 walked to Resident #20's room, opened the door (found Resident #20 indisposed on the toilet) and proceeded to put the souffle cup of pills down for her left the room, shut the door, walked down the hall and back to the medication cart</p> <p>Refer to 7.8.2.36 - Licensed health care professionals are responsible for the administration of medications in accordance with state and federal laws.</p> <p>Based on observations, the facility failed to ensure that licensed personnel conducted the narcotic medication count in accordance with applicable professional standards according to state and federal laws(Staff Trained to Assist with Medications #3 and Licensed Nurse #1). The findings are:</p> <p>A. On 4/21/09 at 7:45 AM during observation of the narcotic count at AM shift change, the following was observed:</p> <p>-Two (2) facility staff (1 unlicensed staff trained in assistance with medications(Staff #3 and Licensed Staff #1) and 1 licensed nursing staff) conducted the narcotic count</p> <p>-Neither staff was observed to sanitize their bare hands prior to beginning the count of the pills</p> <p>-Observations of narcotic medication counts for two (2) facility residents were conducted: Resident #20 and Resident #21. During the count of Hydrocodone pills from a pharmacy bottle, one pill was dropped from the counting</p>	A36	<p><b>2) Potential to Affect</b></p> <p>a) The deficit has the potential to directly affect all residents in which Staff #3 provides services.</p> <p><b>3) Monitor Corrective Action</b></p> <p>a) On 5/11/09, Staff #3 will be given a written test composed of questions taken from the Assisting with Medication test</p> <p>b) Ongoing evaluation will take place weekly for the next 4 weeks after the written test is passed then bi-weekly until the 90 day probation is complete on 7/20/09.</p>	05/11/09

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A36	Continued From page 7  device onto the unsanitized top of the physical medication cart -This pill was picked up by unlicensed Staff #3 and put back into the pharmacy bottle with the rest of the pills. At no time did the licensed personnel (Nurse #1) intervene with unlicensed staff (Staff #3) to prevent the contaminated pill from being put back into the bottle with the other pills.  Refer to 7.8.2.36(F) - Medication Administration Record documentation  Based on record review, the facility failed to ensure that complete documentation was done on Medication Administration Record (MAR) for 1 random resident (Resident #x) of the facility. The findings are:  A. On 4/21/09 at 6:55 AM during review of the Medication Administration Record (MAR) for the AV#1 wing, it was noted that Resident #x, who resides at the facility and is prescribed insulin for her diabetic condition had the following on her Medication Administration Record for the month of April 2009: Medication Administration Record revealed no documentation on 4/9, 4/10, 4/11 (6 holes in the MAR) for the 700 and 2000 doses of insulin prescribed to the resident. There was no notation of the nurses medication notes page of the MAR as to the reason for the missed doses or any information indicating discontinuation, physician changes or other reasoning for lack of documentation.	A36	<b>A36</b>  <b>1) Immediate Correction</b> a) An investigation in to which licensed staff member was responsible for signing the MAR acknowledging they had given the medication. Once the staff was identified, the licensed staff member acknowledged they did not sign the MAR but did give the insulin. Verbal counseling to the licensed staff occurred 4/27/09.  The preceding shift will audit MARS daily to confirm signatures on all medications scheduled to be given with follow up on any areas of concern.	
A66	7 NMAC 8.2.66 Related Regulations & Codes  7.8.2.66 RELATED REGULATIONS AND	A66	<b>2) Potential to Affect</b> a) The deficit has the potential to directly	

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A66	<p>Continued From page 8</p> <p>CODES: Adult residential care facilities subject to these regulations are also subject to other regulations, codes and standards as the same may, from time to time, be amended as follows:</p> <p>A. Health Facility Licensure Fees and Procedures, New Mexico Department of Health 7 NMAC 1.7 (10-31-96).</p> <p>B. Health Facility Sanctions and Civil Monetary Penalties, New Mexico Department of Health, 7 NMAC 1.8 (10-31-96).</p> <p>C. Adjudicatory Hearings, New Mexico Department of Health, 7 NMAC 1.2 (2-1-96). [9-24-76, 7-11-86, 1-11-90, 4-7-97; 7.8.2.66 NMAC - Rn, 7 NMAC 8.2.66, 8-31-00]</p> <p>This REQUIREMENT is not met as evidenced by: Refer to NMAC 7.1.13.10(E) - Incident Reporting, Intake, Processing and Training Requirements (Effective date February 28, 2006) - Consumer and Guardian Orientation Packet</p> <p>Based on record review and interview, the facility failed to ensure that documentation of notice to residents, family members and/or guardians regarding incident reporting was made available in orientation packet for 20 of 20 current residents.</p> <p>The findings are:</p> <p>A. On 4/20/09 and 4/21/09 during review of resident files, it was noted that Resident #1-20 had no documentation of notification to family members/guardians regarding Incident Management Reporting Requirements.</p> <p>B. On 4/22/09 at 1:30 pm during an interview with the Executive Director, she acknowledged that no documentation was available indicating</p>	A66	<p>affect all residents in which the licensed staff provides services.</p> <p><b>3) Monitor Corrective Action</b></p> <p>a) Monthly audit performed by the Resident Care Coordinator of the Medication Administration Records started 04/01/09</p> <p><b>A66</b></p> <p><b>1) Immediate Correction</b></p> <p>b) Residents, family members and caregivers will receive an Orientation Packet to include our Incident Reporting policies and the Incident Management Reporting Requirements. An acknowledgement form will be included that residents, families and guardians will sign and return . Acknowledgement forms will</p>	05/08/09

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A66	Continued From page 9  that residents received notification of reporting requirements.	A66	<p>be placed in each residents file. Individual education for all new residents will take place at admission and will be available for current residents, families and guardians.</p> <p><b>2) Potential to Affect</b> a) The deficit has the potential to affect all residents/families and guardians who need to report an incident of ANE.</p> <p><b>3) Monitor Corrective Action</b> a) The Admissions Department will keep track of acknowledgement forms as they are returned and will follow up with residents/families and guardians to ensure everyone responds.</p>	05/22/09