

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 2167	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 04/01/2013
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NAME OF PROVIDER OR SUPPLIER
COTTONBLOOM ASSISTED LIVING COMMUNITY

STREET ADDRESS, CITY, STATE, ZIP CODE
**5626 COTTONBLOOM COURT
LAS CRUCES, NM 88006**

(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 000	Initial Comments Complaint investigations were completed for intakes NM00028527, NM00028851, NM00028992, and NM00028964 on 04/01/13 for the state requirements of 7 NMAC 8.2, Regulations for Assisted Living. Complaints NM00028527 and NM00028851 were unsubstantiated with no deficiencies cited as a result of these complaints. Complaint NM00028964 was substantiated with deficiencies cited as a result of this complaint.	A 000		
A 033	7 NMAC 8.2.33 Resident Rights RESIDENT RIGHTS: All licensed facilities shall understand, protect and respect the rights of all residents. A. Prior to admission to a facility, a resident and legal representative shall be given a written description of the legal rights of the resident, translated into another language, if necessary, to meet the resident's understanding. B. If the resident has no legal representative and is incapable of understanding his or her legal rights, a written copy of the resident's legal rights shall be provided to the most significant responsible party in the following order: (1) the resident's spouse; (2) significant other; (3) any of the resident's adult children; (4) the resident's parents; (5) any relative the resident has lived with for six or more months before admission; (6) a person who has been caring for, or paying benefits on behalf of the resident;		POC: The facility will ensure that all residents are freed from physical and emotional abuse, neglect, and misappropriation /or exploitation by following current physician's orders for all residents. In the event that medications are not given as ordered by the physician, staff will document the reason on the resident's MAR. Staff will also document all efforts made to follow physician's orders, obtain clarification, and/or what exactly needs clarification. Medication Technician (MT) to document and communicate to Assisted Living Director (ALD) if unable to obtain needed clarification. Audit to be conducted by ALD. ALD and/or designee to review and monitor to ensure that current physician's orders are being followed for all residents. Resident #1 is no longer residing in the facility. All residents had the potential to be affected by this violation. All MT's to be trained by ALD on medication availability and process to follow in the event clarification of physician's orders is needed.	April 4, 2014

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HEALTH FACILITY LICENSING & CERTIFICATION

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4/8/2014

Division of Health Improvement
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

A. K. A. /
STATE FORM

Executive Director

04-03-2014

Division of Health Improvement

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NAME OF PROVIDER OR SUPPLIER COTTONBLOOM ASSISTED LIVING COMMUNITY		STREET ADDRESS, CITY, STATE, ZIP CODE 5625 COTTONBLOOM COURT LAS CRUCES, NM 88005		
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A 033	Continued From page 1 (7) a placing agency; (8) resident advocate; or (9) the ombudsman. C. The resident rights shall be posted in a conspicuous public place in the facility and shall include the telephone numbers for the incident management hotline and for the state ombudsman program. D. To protect resident rights, the facility shall: (1) treat all residents with courtesy, respect, dignity and compassion; (2) not discriminate in admission or services based on gender, sexual orientation, resident's age, race, religion, physical or mental disability, or nationality; (3) provide residents written information about all services provided by the facility and their costs and give advance written notice of any changes; (4) provide residents with a safe and sanitary living environment; (5) provide humane care for all residents; (6) provide the right to privacy, including privacy during medical examinations, consultations and treatment; (7) protect the confidentiality of the resident ' s medical record; (8) protect the right to personal privacy, including privacy in personal hygiene; privacy during visits with a spouse, family member or other visitor; and privacy in the resident's own room; (9) protect the right to communicate privately and freely with any person, including private telephone conversations and private correspondence; and the right to receive visits from family, friends, lawyers, ombudsmen and community organizations; (10) prohibit the use of any and all physical and chemical restraints; (11) ensure that residents:	A 033		

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A 033	Continued From page 2 (a) are free from physical and emotional abuse neglect and misappropriation/or exploitation; (b) are free from financial abuse and misappropriation by facility staff or management; (c) are free to participate in religious, social, community and other activities and freely associate with persons in and out of the facility; (d) are free to leave the facility and return without unreasonable restriction; (e) are given a fifteen (15) calendar day, written notice before room transfers or discharge from the facility unless there is immediate danger to self or others in the facility; (f) have an environment that fosters social interaction and avoids social isolation; (g) or their surrogate decision makers, are informed of and consent to the services provided by the facility; (h) have the right to voice grievances to the facility staff, public officials, the ombudsmen, any state agency, or any other person, without fear of reprisal or retaliation; (i) have the right to have their complaints addressed within fourteen (14) calendar days or sooner; (j) have the right to participate in the development of their care plan/ISP; (k) have the right to choose a doctor, pharmacist and other health care provider(s); (l) have the right to participate in medical treatment decisions and formulate advance directives such as living wills and powers of attorney; (m) have the right to keep and use personal possessions without loss or damage; (n) have the right to manage and control their personal finances; (o) have the right to freely organize and participate in a resident association that may	A 033		

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A 033	<p>Continued From page 3</p> <p>recommend changes in the facility's policies, services and management;</p> <p>(p) shall not be required to work for the facility; and</p> <p>(q) are protected from unjustified room transfers or discharge.</p> <p>E. The resident's rights shall not be restricted unless this restriction is for the health and safety of the resident, agreed to by the resident or the resident's surrogate decision maker and outlined in the resident's individual service plan.</p> <p>[7.8.2.33 NMAC - Rp, 7.8.2.34 NMAC, 01/15/2010]</p> <p>This REQUIREMENT is not met as evidenced by: Refer to 7.8.2.33. D. (11) ensure that residents: (a) are free from physical and emotional abuse, neglect, and misappropriation/or exploitation;</p> <p>Based on record review and interview, the facility failed to ensure the freedom from neglect of a resident by not following current Physician's orders that were sent to the facility upon admittance to the facility for medications administration for 1 (#1) of 3 (#1 through #3) sampled residents. This deficient practice of neglect likely resulted in the resident sustaining both physical and mental harm by behaviors of agitation and panic that caused him to injure himself. The findings are:</p> <p>A. Review of records for former Resident #1 revealed the following:</p> <ol style="list-style-type: none"> 1. Date of admission was 08/09/12; 2. Discharge Plan from a Behavioral Health 	A 033		

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A 033	<p>Continued From page 4</p> <p>Clinic (BHC) dated 08/09/12 revealing an admission date of 07/23/12 with a diagnosis of, "Axis I: 1) Major Depressive Disorder, 2) severe recurrent mood NOS, Dementia NOS; Axis II: none; Axis III: Parkinson's disease; Axis IV: Severe health problems; Axis V: 25 on admin;"</p> <p>3. Medications orders from BHC dated as faxed to the facility on 08/10/12 revealed Copies of Prescriptions from BHC dated 08/09/12 revealed the following:</p> <p>a) Effexor XR 150 mg [symbol for take 2 tablets] Po [by mouth] QAM [once in the morning] #60 [60 tablets],</p> <p>b) Clonazepam 2 mg [symbol for take 1 tab] Po [by mouth] QHS [once at bedtime] #30 [30 tablets],</p> <p>c) Risperdal 3 mg [symbol for take 1 tablet] PO [by mouth] QHS [once at bedtime] #30 [30 tablets], and</p> <p>d) Requip XL 6 mg [symbol for take 1 tab] Po [by mouth] QHS #30 [30 tablets].</p> <p>4. Review of the facility August, 2012 Medication Administration Record (MAR) revealed:</p> <p>a) "8/9/12 Risperdal 3 mg [with a line drawn through the 3 mg and 0.5 mg written in] Take pill by mouth daily at night." The MAR revealed the Risperdal was held from 8/10/12 through 8/21/12 and on 8/24/12 with no notes as to why it was held."</p> <p>b) "8/9/12 Clonazepam 2 mg Take by mouth daily at night." The medication was not given on 08/17/12 through 08/21/12, and on 08/24/12. The only notes are for 08/21/12 which states the resident splt it out and for 08/24/12 which states all 8 pm pills, resident asleep.</p> <p>c) "8/9/12 Requip XL 6 mg Take every day at night." It was not given on 08/16/12 through 08/28/12 with no notes except for 08/16/12 note read, "Not in stock," and on 08/24/12 which</p>	A 033		

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A 033	<p>Continued From page 5</p> <p>states, "All 8 pm pills, resident asleep." (Note: There should have been at least a 30 day supply of Requip starting on 08/09/12.)</p> <p>5. No documentation was in the records to reveal the facility had made any attempt to get the medications orders clarified or any documentation to show what needed clarification.</p> <p>B. Review of the web site "Drugs.com," revealed the following:</p> <ol style="list-style-type: none"> 1. Risperdal is prescribed for severe behavior problem; 2. Clonazepam is prescribed for Panic Disorder; 3. Requip XL is prescribed for treatment of Parkinson's Disease to improve poor motor functioning. <p>C. Review of facility Progress Notes for former Resident #1 revealed the following:</p> <ol style="list-style-type: none"> 1. Former Medication Assistant/Resident Assistant (MA/RA) #60 on 08/10/12 at 7:30 pm wrote, "... Resident was agitated through whole shift. ..." 2. MA/RA #61 on 08/11/12 at 2:50 am wrote, "Resident became somewhat agitated when staff was assisting him with urinal. ..." 3. MA/RA #61 on 08/11/12 at 10:00 pm wrote, "... Resident was fine in the morning [sic] no problems just [sic] when the wife came in he was [sic] started to get very agitated [sic] ..." 4. MA/RA #63 on 08/12/12 at 4:50 am wrote, "... Resident got agitated when assisted with the urinal. ... Resident refused vitals. ..." 5. MA/RA #64 on 08/15/12 at 9:00 am wrote, "... Resident is given medication with some apple sauce, but resident spit them out into hands, Colace, Proscar, Effexor. ..." 6. MA/RA #63 on 08/18/12 at 4:45 am wrote, "... Resident got out of bed several times at 	A 033		

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A 033	<p>Continued From page 6</p> <p>night, walking the hall way. Resident came close to falling 2 times. . . . Resident was up until 4 am and was yelling and screaming for help. MA had to sit with resident in his room for 45 minutes . . ."</p> <p>7. MA/RA #63 on 08/19/12 at 5:20 am wrote, "Resident has been yelling most of this shift. He got out of bed and was walking very fast and almost lost his balance. Resident was assisted to bed and MA stayed with him for several hours through this shift. . . ."</p> <p>8. Former MA/RA #60 on 08/19/12 (no time noted) wrote, "Resident was up walking for the whole shift. Gait is unsteady. Resident goes in other residents rooms. Resident opens outside doors and makes alarms go off. . . ."</p> <p>9. MA/RA #63 on 08/20/12 at 5:20 am wrote, "Resident was up and yelling for help for several hours. MA would go into his room and sit in there until he calmed down. MA was helping another resident into the restroom when [former Resident #1] came out of the hall way walking real fast. Resident almost lost his balance twice. MA took resident back to his bed and gave him a drink of water. Resident started yelling and waking his roommate. His room mate was very confused. MA sat in resident's room from 12 am until 3:30 am. . . ."</p> <p>10. Former MA/RA #60 on 08/21/12 at 9:00 pm wrote, ". . . After dinner Resident began wandering, acting out, setting off alarms, going into other residents' rooms causing RA/MA to put residents in bed and lock their doors. Resident was outside courtyard throwing lawn chairs. Resident fell, lost balance due to uneven grass. Resident refused vitals at this time. Hospice nurse with resident."</p> <p>11. MA/RA #63 on 08/22/12 at 5:20 am wrote, "Resident had a busy night until 11:20 pm when resident went to bed. He was pacing and kicking doors, going into wrong rooms and scaring</p>	A 033		

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A 033	<p>Continued From page 7</p> <p>everyone."</p> <p>12. (Signature not legible) on 08/24/12 at 1:50 pm wrote, "... Resident got up and destroy [sic] his bedroom. Then he got all the towels and started throwing them around the bathroom. ..."</p> <p>13. Former MA/RA #60 on 08/24/12 at 10:00 pm wrote, "... Resident became agitated at dinner with wife [sic] threw ice cream all over table and went to bed and stayed there the rest of shift. Missed 8 pm medication. ..."</p> <p>14. Resident Care Notes for 08/26/12 through 08/28/12 missing from records. No records of incidents during this time period were provided to the surveyor.</p> <p>15. MA/RA #63 on 08/29/12 at 4:30 am wrote, "Resident is on alert charting due to dislocating his finger (pinky). and return [sic] to facility. Resident refused his meds on the 2 pm to 10 pm shift and his wife asked MA/RA if I could just give him his scheduled meds on this shift, 10 pm to 6 am. By her request, MA/RA assisted him with his missed meds and he went straight to bed. ..."</p> <p>D. Review of the phone log from the Hospice provider revealed the first notification to hospice by the facility in reference to former resident # 1 behaviors was 08/21/12 at 8:49 pm. The call was from the facility nurse, to inform Hospice former resident #1 was agitated, throwing furniture outside, and fell into the grass scraping his forehead and right knee.</p> <p>E. In an interview with the Interim Administrator on 03/26/13 at 2:25 pm, in reference to former resident #1, the Interim Administrator stated, "... We caught him about to smother his roommate with a pillow. ..."</p> <p>F. In an interview with the wife of former Resident #1 on 04/01/13 at 1:04 pm, the wife</p>	A 033		

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A 033	Continued From page 8 acknowledged she was told by the facility there was a discrepancy with his hallucination medication and it was withheld, which caused behavior problems that led to him injuring himself. She further acknowledged she felt the facility did nothing to get whatever the discrepancy was with the medications corrected.	A 033		
A 035	7 NMAC 8.2.35 Medication 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. 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. 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. C. PRN (pro re nada) medication.	A 035		

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A 035	Continued From page 9 (1) Physician or physician extender's orders for 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. (2) The utilization of PRN medications shall be reviewed routinely. Frequent or escalating use of PRN medications shall be reported to the PCP. 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. 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. F. Medications prescribed for one resident shall not be used for another resident. 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: (1) the resident's name; (2) any known allergies to medication that the resident has; (3) the name of the resident's PCP or the prescriber of the medication;	A 035	Tag: A 035 – 8.2.35 Medication POC: The facility will follow current physician's orders for medication administration for all residents from the time of admission to the time of discharge. In the event that medications are not or cannot be given as ordered by the physician, staff will document the reason on the resident's MAR. Staff will also document all efforts made to follow physician's orders, obtain clarification, and/or what exactly needs clarification with regards to prescribed medications. Medication Technician (MT) to document and communicate to Assisted Living Director (ALD) if unable to obtain needed clarification. Audit to be conducted by ALD, ALD and/or designee to review and monitor to ensure that current physician's orders are being followed for all residents. ALD and/or designee will review the MAR weekly to ensure each medication has been documented with the appropriate entry. Resident #1 is no longer residing in the facility. All residents had the potential to be affected by this violation. All MT's to be trained by ALD on medication availability and process to follow in the event clarification of physician's orders is needed.	April 4, 2014
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A 035	<p>Continued From page 10</p> <p>(4) the diagnosis or reason for the medication; (5) the name of the medication, including the drug product brand name and the generic name; (6) notation if the medication is a schedule II-IV drug; (7) the dosage of the medication; (8) the strength of the medication; (9) the frequency or how often the medication is to be taken or given; (10) the route of delivery for the medication (mouth, eye, ear, other); (11) the method of delivery for the medication (pills, drops, IM injection, other); (12) the date that the medication was started or discontinued; (13) any change in the medication order; (14) pre-medication information (i.e., pulse, respiration, blood pressure, blood sugar) as required by the medication order; (15) the date and time that the medication is self-administered, administered with assistance or is administered; (16) the initials and signature of the person assisting with or administering the medication; (17) the desired results obtained from or problems encountered with the medication (pain relieved, allergic reaction, etc.); (18) any refused dose of medication; (19) any missed dose of medication; and (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</p>	A 035		

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(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 035	<p>Continued From page 11</p> <p>surrogate decision maker. If applicable, 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> <ul style="list-style-type: none"> (1) the resident's name; (2) the name of the medication; (3) the date that the prescription was issued; (4) the prescribed dosage and the instructions for administration of the medication; and (5) the name and title of the prescriber. <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. [7.8.2.35 NMAC - Rp, 7.8.2.36 NMAC, 01/15/2010]</p> <p>This REQUIREMENT is not met as evidenced by: Refer to 7.8.2.35 (First paragraph, second sentence)</p> <p>Based on record review and interview, the facility failed to follow current Physician's orders for medications administration for 1 (#1) of 3 (#1 through #3). This deficient practice has the potential to harm the physical and/or mental</p>	A 035		

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 2167	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 04/01/2013
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NAME OF PROVIDER OR SUPPLIER COTTONBLOOM ASSISTED LIVING COMMUNITY	STREET ADDRESS, CITY, STATE, ZIP CODE 6626 COTTONBLOOM COURT LAS CRUCES, NM 88006
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(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 035	<p>Continued From page 12</p> <p>health of a resident by their medical conditions not receiving appropriate treatment. The findings are:</p> <p>A. Review of records for former Resident #1 revealed the following:</p> <ol style="list-style-type: none"> 1. Date of admission was 08/09/12; 2. He was admitted to Hospice on 08/09/12; 3. Discharge Plan from a Behavioral Health Clinic (BHC) dated 08/09/12 revealing an admission date of 07/23/12 with a diagnosis of Axis I: 1) Major Depressive Disorder, 2) severe recurrent mood NOS, Dementia NOS; Axis II: none; Axis III: Parkinson's disease; Axis IV: Severe health problems; Axis V: 25 on admin; 4. Medications orders from BHC dated as faxed to the facility on 08/10/12 revealed Copies of Prescriptions from BHC dated 08/09/12 revealed the following: <ol style="list-style-type: none"> a) Effexor XR 150 mg [symbol for take 2 tablets] Po [by mouth] QAM [once in the morning] #60 [60 tablets], b) Clonazepam 2 mg [symbol for take 1 tab] Po [by mouth] QHS [once at bedtime] #30 [30 tablets,] c) Risperdal 3 mg [symbol for take 1 tablet] PO [by mouth] QHS [once at bedtime] #30 [30 tablets], and d) Requip XL 6 mg [symbol for take 1 tab] Po [by mouth] QHS #30 [30 tablets]. 5. Review of the facility August, 2012 Medication Administration Record (MAR) revealed: <ol style="list-style-type: none"> a) "8/9/12 Risperdal 3 mg [with a line drawn through the 3 mg and 0.5 mg written in] Take pill by mouth daily at night." The MAR revealed the Risperdal was held from 08/10/12 through 08/21/12 and on 08/24/12 with no notes as to why it was held." b) "8/9/12 Clonazepam 2 mg Take by mouth 	A 035		

Division of Health Improvement

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NAME OF PROVIDER OR SUPPLIER COTTONBLOOM ASSISTED LIVING COMMUNITY	STREET ADDRESS, CITY, STATE, ZIP CODE 5525 COTTONBLOOM COURT LAS CRUCES, NM 88005
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A 035	<p>Continued From page 13</p> <p>daily at night." The medication was not given on 08/17 through 08/21/12, and on 08/24/12. The only notes are for 08/21/12 which states the resident spit it out and for 08/24/12 which read, "all 8 pm pills, resident asleep."</p> <p>c) "8/9/12 Requip XL 6 mg Take every day at night." It was not given on 08/16 through 08/28/12 with no notes except for 08/16/12 note read, "Not in stock," and on 08/24/12 which states, "All 8 pm pills, resident asleep." (Note: There should have been at least a 30 day supply of Requip starting on 8/9/12.)</p> <p>6. No documentation was in the records to reveal the facility had made any attempt to get the medications orders clarified or any documentation to show what needed clarification.</p> <p>B. Review of the web site "Drugs.com," revealed the following:</p> <ol style="list-style-type: none"> 1. Risperdal is prescribed for severe behavior problem; 2. Clonazepam is prescribed for Panic Disorder; 3. Requip XL is prescribed for treatment of Parkinson's Disease to improve poor motor functioning. <p>C. In an interview with the Interim Administrator, on 03/21/13 at 9:50 am, the Interim Administrator acknowledged the medication orders were unclear and the facility did not know what dosages the resident was suppose to get. When asked exactly what was unclear, she said, "I can't remember." She further acknowledged that some of the medications that the resident arrived with were not the same dosages that were listed on the discharge orders. When asked if the facility had requested clarification of the orders, the Interim Administrator acknowledged she didn't remember. The Interim Administrator</p>	A 035		

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NAME OF PROVIDER OR SUPPLIER COTTONBLOOM ASSISTED LIVING COMMUNITY	STREET ADDRESS, CITY, STATE, ZIP CODE 5528 COTTONBLOOM COURT LAS CRUCES, NM 88005
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A 035	<p>Continued From page 14</p> <p>further acknowledged he was violent and the Former Administrator should have never admitted him to this facility. When asked why the facility didn't follow the orders from the [name of a behavioral health facility], the interim administrator had no comment.</p> <p>D. In an interview with the wife of former Resident #1 on 04/01/13 at 1:04 pm, she acknowledged there was a discrepancy with his hallucination medication and it was withheld, which caused behavior problems that led to him injuring himself. She further acknowledged she felt the facility did nothing to get the discrepancy with the medications corrected.</p>	A 035		