| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 5707 | A. BUILDING _____ B. WING _____ | 12/04/2007 |

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| SUNRISE OF ALBUQUERQUE | 4900 TRAMWAY RIDGE DRIVE NE ALBUQUERQUE, NM 87111 |

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| A19 | 7 NMAC 8.2.19 ADMISSIONS<br><br>7.8.2.19 ADMISSIONS: No resident shall be admitted or retained who is below the age of eighteen (18) or for whom the facility is unable to provide appropriate care. EXCEPTION: Maternity Shelters may accept residents below the age of eighteen (18).<br>A. ADMISSION INTERVIEW. The Director of the facility or a designee responsible for admission and retention decisions, shall meet with the resident or the resident's agent or guardian, if the resident lacks decision-making capacity, and shall provide the resident with:<br>(1) The facility's program narrative.<br>(2) The facility's rules.<br>(3) The facility's admission agreement, including costs and charges, refund provision, and contract termination policies.<br>(4) The facility's bed hold policy.<br>(5) Information about the resident's right under New Mexico Law to make decisions regarding health care, including the right to make advance directives.<br>(6) A written description of the legal rights of the residents translated into another language, if necessary.<br>(7) The facility's staffing pattern.<br>B. RESTRICTIONS ON ADMISSIONS: Adult residential care facilities shall not admit or retain individuals requiring continuous nursing care. Conditions or circumstances that usually require continuous nursing care, may include, but not limited to the following:<br>(1) Ventilator dependency.<br>(2) Pressure sores where skin loss penetrates beyond the skin, and into deeper tissue or bone, which are classified as Stage III or IV.<br>(3) Intravenous therapy or injections directly into the vein.<br>(4) Airborne infectious disease, in a communicable state, including tuberculosis, but | A19 | ES Scanned 01-04-08 | |

If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Daniel Sanders | TITLE: Executive Director | (X6) DATE: 12/26/07



JAN - 2 2008

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| A19 | Continued From Page 1 | A19 | | |

excluding infections such as the common cold.

(5) Any condition requiring either physical or chemical restraints.

(6) Nasogastric tubes / gastric tubes.

(7) Tracheostomy care.

(8) Individuals presenting an imminent physical threat or danger to self or others.

(9) Individuals whose physician certifies that placement is no longer appropriate.

C. ADMISSION/RETENTION EXCEPTIONS: If a resident requires a greater degree of care than the facility would normally provide, or is permitted to provide, and the resident wishes to be re-admitted or to remain in the facility, and the facility wishes to re-admit or retain the resident, the facility must:

(1) Convene a team, comprised of:

(a) The facility director.

(b) The resident.

(c) The resident's agent, guardian or surrogate decision maker.

(d) The resident's advocate, such as the resident's case manager, Ombudsman, or social worker.

(e) If the treating physician is unable to meet with the team, then consultation and recommendations via phone is acceptable.

(f) Other appropriate health care professionals.

(2) The team shall jointly determine if the resident should be admitted or allowed to remain in the facility. The team must approve a individual service plan that meets the specific needs of the resident. Such team approval must be in writing, signed and dated by all team members, must be maintained in the resident's record, and must:

(a) Be based upon a individual service plan which identifies the resident's specific needs and addresses the manner that such needs will be met.

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| A19 | Continued From Page 2<br><br>(b) Ensure that the facility has and will maintain an evacuation rating of prompt or slow as determined by the Fire Safety Equivalency System (FSES).<br>(c) Be based upon an assessment of the health, safety and well-being of the other facility residents.<br>(d) Assess the impact that meeting the specific needs of the resident as set out in the individual service plan will have on the staff and on the other residents.<br>(3) Notify the Licensing Authority within five (5) days of the completion of team approval. Such notification of team approval must be submitted in writing and include evidence of the team's consideration of items 7.8.2.19C2(a) through 7.8.2.19C2(d) above.<br>[9-24-76, 7-11-86, 1-11-90, 4-7-97;7.8.2.19 NMAC - Rn. 7 NMAC 8.2.19, 8-31-00]<br><br>This Requirement is not met as evidenced by:<br>Refers to 7.8.2.19(C)(2) - Admission/Retention Exceptions documentation<br><br>Based on record review and interview, the facility failed to maintain all documentation associated with the individual service plan as required. The findings are:<br><br>A. On 11/4/07 at 1:55 PM during review of the resident files, it was noted that Resident #3's (who resides at the facility and is receiving services from a Hospice agency) file did not contain the team sign in roster for Admission/Retention meeting and the entire careplan for all services being received from all involved entities.<br><br>B. On 12/4/07 at 2:21 PM during interview with the Care Coordinator, she stated that she | A19 | Responses to the cited deficiencies do not constitute an admission or an agreement by the facility of the truth of the facts alleged or conclusion set forth in the Statement of Deficiencies.<br>The Plan of Correction is prepared solely as a matter of compliance with federal and/or state law.<br><br>**A19 ADMISSIONS**<br><br>1. Address how all violations identified in the official written report will be corrected:<br>A special ISP meeting with Sunrise staff, the family, and the Hospice provider will be held to insure that all are in agreement with the Individual Service Plan.<br>2. Identify other residents having the potential to be affected by the same deficient practice:<br>All residents who may require or request services from a third party provider, shall have a special ISP meeting between Sunrise staff, the family and the third party provider to insure that all are in agreement with the ISP.<br>3. Monitor its corrective action: The Executive Director, the Health Care Coordinator, and/or the Reminiscence Coordinator shall be responsible for monitoring records on a quarterly basis to insure that this requirement is followed.<br>4. Specify a date upon which the corrective action will be completed: All residents who may be affected will have the ISP completed by January 5, 2008. | |

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| A19 | Continued From Page 3<br><br>understood the issue. | A19 | | |
| A33 | 7 NMAC 8.2.33 REPORTING OF INCIDENTS<br><br>7.8.2.33 REPORTING OF INCIDENTS:<br>A. The facility must insure that all suspected cases or known incidents of resident abuse, neglect, exploitation, and mistreatment are reported. A facility must 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 and Adult Protective Services (APS) by the next business day. In no instance may a facility delay a report to Adult Protective Services or to the Licensing Authority, while an internal investigation is being conducted.<br>B. The facility is responsible for documenting all incidents, within five (5) days of the incident, and having on file, the following:<br>(1) A narrative description of the incident.<br>(2) Results of the facility's investigation.<br>(3) The facility action, if any.<br>[7-1-64, 9-15-70, 5-26-72, 7-11-86, 4-7-97; 7.8.2.33 NMAC - Rn 7 NMAC 8.2.33, 8-31-00]<br>This Requirement is not met as evidenced by:<br>Refers to 7.8.2.33 - Reporting of Incidents<br><br>Based on record review and interview, the facility failed to ensure that incidents or unusual occurances that have or could threaten the health, safety or welfare of the residents were reported as required.<br><br>The findings are:<br><br>A. On 12/4/07 at 2:15 PM during review of the facility's incident file, the following was noted: | A33 | **A33 REPORTING OF INCIDENTS**<br><br>1. Address how all violations identified in the official written report will be corrected:<br>A. The community was unaware that Medication Errors were a reportable incident. It was reported to the resident's attending physician immediately and her orders were followed. The incident was not reported to the State agency but all future medication errors will be.<br>B. The resident fell in her room with the family present. The family decided to take her to the ER to have her checked out. She was seen by an ER physician and had no apparent injuries. The community was unaware that residents taken to the ER by family was reportable. The incident was not reported to the State agency but all future ER related incidents will be reported.<br>2. Identify other residents having the potential to be affected by the same deficient practice:<br>All residents have the potential to be affected by this type incident.<br>3. Monitor its corrective action:<br>The Health Care Coordinator, Reminiscence Coordinator, or Executive Director shall be responsible for monitoring Incident Reports and insuring that they are reported, as required<br>4. State a date upon which the corrective action will be completed:<br>The community shall have a system in place to insure that all residents who may be affected by this deficiency by January 5, 2008. | |

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| A33 | Continued From Page 4<br><br>1. Record of incident which occured on 7/22/07 for Resident #1 which indicated instance of a medication error. There was no documentation to show that this incident had been reported to the required state agencies.<br><br>2. Record of incident which occured on 7/25/07 for Resident #2 which indicated that a resident had to be transferred out of the facility for emergency care following a fall at the facility.<br><br>B. On 12/4/07 at 2:24 PM during interview with the Care Coordinator, she stated that she understood the issue. | A33 | | |
| A35 | 7 NMAC 8.2.35 CUSTODIAL DRUG PERMIT<br><br>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.<br>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.<br>(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. | A35 | | |

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(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.

(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

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| A35 | Continued From Page 6<br><br>enable an accurate reconciliation.<br>(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.<br>[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]<br><br>This Requirement is not met as evidenced by:<br>Refers to 7.8.2.35 - Custodial Drug Permit - Consulting Pharmacist<br><br>Based on record review and interview, the facility failed to ensure that records of visits by the consultant pharmacist were maintained. The findings are:<br><br>A. On 12/4/07 at 11:45 AM during review of administrative files, it was noted that the documentation from the consultant pharmacist for the first two quarters of 2007 were not among the paperwork.<br><br>B. On 12/4/07 at 2:24 PM during interview with the Care Coordinator, she stated that this paperwork was not available. | A35 | **A35 CUSTODIAL DRUG PERMITS**<br><br>1. Address how all violations identified in the official written report will be corrected:<br>The ED contacted the consulting pharmacist and was provided with a copy of the consult visit on 5/03/07. In addition, the consultant pharmacist visited the community and performed an additional visit on 12/08/07. The Ed and HCC met with the consultant and a regular schedule will be maintained in 2008.<br>2. Identify other residents having the potential to be affected by the same deficient practice:<br>All residents who are assisted with medications may be affected by this practice.<br>3. Monitor its corrective action:<br>The HCC and the ED shall be responsible for assuring that the consultant pharmacist will make regular quarterly visits to the community. A schedule has been set for quarterly consults.<br>4. Specify a date upon which the corrective action will be completed:<br>This deficient practice was corrected on 12/8/ 2008. | |
| A66 | 7 NMAC 8.2.66 RELATED REGULATIONS AND CODES<br><br>7.8.2.66 RELATED REGULATIONS AND 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:<br>A. Health Facility Licensure Fees and Procedures, New Mexico Department of Health 7 | A66 | | |

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| A66 | Continued From page 7<br>7.8.2.66 RELATED REGULATIONS AND 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:<br>A. Health Facility Licensure Fees and Procedures, New Mexico Department of Health 7 NMAC 1.7 (10-31-96).<br>B. Health Facility Sanctions and Civil Monetary Penalties, New Mexico Department of Health, 7 NMAC 1.8 (10-31-96).<br>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]<br>This REQUIREMENT is not met as evidenced by:<br>Refer to NMAC 7.1.9.8 - Caregivers Criminal History Screening Requirements (Effective January 1, 2006) - All applicants to whom an offer of employment is made must consent to a nationwide and statewide screening.<br><br>Based on record review and interview, the facility failed to have documentation that direct care staff had been cleared through the New Mexico Caregivers' Criminal History Screening Program (CCHSP) for 1 of 17 employee files reviewed (Staff #4). The findings are:<br><br>A. On 12/4/07 at 3:20 PM during review of employee records, it was noted that Staff #4, with a hire date of 10/30/03 did not have on file documentation of CCHSP statewide update screening addressed to the facility conducted subsequent to hire within the required timeframes nor documentation of a full Caregivers Criminal History Screening (CCHSP) clearance addressed to the facility conducted subsequent to hire within the required timeframes. | A66 | **A66 RELATED REGULATIONS & CODES**<br><br>I. 1. Address how all violations identified in the official written report will be corrected:<br>A. The letter in question was addressed to the employee, instead of the community, and was accepted by the community at that time. The community will send the employee to have her screening done over and resubmitted.<br>B. Identify other residents having the potential to be affected by the same deficient practice:<br>Although this does not affect residents directly, we will insure that all employees have been screened as provided by regulations. All employee records will be audited to insure that the correct letter is on file. Any who are not in compliance will be sent to have the screening redone.<br>C. Monitor its corrective action:<br>The ED will have all employee records audited to insure that the correct documentation is on file. The practice of accepting letters to an employee instead of the community will cease immediately.<br>D Specify a date upon which the corrective action will be completed: All employee files will be audited by 1/05/07 and any discrepancies will be corrected. | |

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| A66 | Continued From Page 8<br><br>Refer to NMAC 7.1.13.9(B)(2) - Incident Reporting, Intake, Processing and Training Requirements (Effective date February 28, 2006) - Incident Management System Reporting Requirements using Division Incident Report Form<br><br>Based on record review and interview, the facility failed to ensure that the most current incident reporting form was available for use by staff of the facility. The findings are:<br><br>A. On 12/4/07 at 3:29PM during review of the administrative files, it was noted that the required form for documentation for abuse, neglect and exploitation, and reporting requirements was not among facility paperwork.<br><br>B. On 12/4/07 at 3:30 PM during interview with the Executive Director, he acknowledged the issue.<br><br>Refer to NMAC 7.1.13.10(C)(1)(a-f) Incident Reporting, Intake, Processing and Training Requirements (Effective date February 28, 2006) - Incident Management System Training Curriculum Requirements on incident policies and procedures, timely reporting, unexpected deaths and other reportable incidents.<br><br>Based on record review and interview, the facility failed to ensure training on Incident Management System with the required curriculum for 100% of staff. The findings are: | A66 | II. A. The community was unaware that the incident reporting form is updated yearly. The ED has since downloaded the most recent form and has scheduled in-services for department managers to acquaint them with the form and to develop an internal procedure for implementation of the entire program.<br>B. All employees will be in-serviced and trained at the next staff meeting (Town Hall) in January on the reporting system.<br>C. The Ed will be responsible for insuring training for all new employees during Orientation.<br>D. Training for all employees will be 1/17/08. | |

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| A66 | Continued From Page 9<br><br>A. On 12/4/07 at 10:40AM during review of the employee files it was noted that the required training documentation for abuse, neglect and exploitation, and reporting requirements for NMAC 7.1.13 was not among administrative paperwork.<br><br>B. On 12/4/07 at 3:30 PM during interview with the Executive Director, he acknowledged the issue.<br><br>Refer to NMAC 7.1.13.10(C)(1)(a-f) Incident Reporting, Intake, Processing and Training Requirements (Effective date February 28, 2006) - Incident Management System Training Curriculum Requirements on incident policies and procedures, timely reporting, unexpected deaths and other reportable incidents.<br><br>Based on record review and interview, the facility failed to ensure that a curriculum based on Incident Reporting, Intake, Processing and Training Requirements was available for review. This affects 100% of staff and has the potential to affect 100% of the resident population. The findings are:<br><br>A. On 12/4/07 at 3:15 during review of the employee files it was noted the following required training documentation was missing:<br><br>- NMAC 7.2.13 regulatory training abuse, neglect and exploitation, and other reporting | A66 | III. A. Training for all employees on abuse, neglect, and exploitation is done during new employee orientation and annually in Town Hall. However, training did not consist of the new regulations and will be revised to comply with the new regulations.<br>B. The ED will insure that all employees will be trained in the new format required.<br>C. The ED will personally provide new employee orientation training and will monitor documentation of attendance.<br>D. This will begin on 1/17/07.<br><br>IV. A. Please see III.A.B.C.D. above.<br><br>V. A. Please see III.A.B.C.D. above.<br><br>VI. A. Please see III.A.B.C.D above. | |

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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 |
|---|---|---|---|---|
| A66 | Continued From Page 10<br><br>requirements documents or certificate of attendance with dates of training<br><br>B. On 12/4/07 at 3:30 PM during interview with the Executive Director, he acknowledged the issue.<br><br>Refer to NMAC 7.1.13.10(C)(2-3) Incident Reporting, Intake, Processing and Training Requirements (Effective date February 28, 2006) - Requirement to train new employees within 30 days of hire and current employees within 90 days of the effective date of this ruling.<br><br>Based on record review and interview, the facility failed to ensure required training within the time frames set in accordance to regulations set forth in the Incident Reporting, Intake, Processing and Training Requirements (NMAC 7.1.13, effective February 28, 2006) for 100% of staff. The findings are:<br>The findings are:<br><br>A. On 12/4/07 at 3:15 PM during review of the employee files it was noted the following required training documentation was missing:<br><br>- NMAC 7.2.13 regulatory training abuse, neglect and exploitation, and other reporting requirements documents or certificate of attendance with dates of training<br><br>B. On 12/4/07 at 3:30 PM during interview with the Executive Director, he acknowledged the issue. | A66 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 5707 | A. BUILDING _____ B. WING _____ | 12/04/2007 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
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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 |
|---|---|---|---|---|
| A66 | Continued From Page 11<br><br>Refer to NMAC 7.1.13.10(D) Incident Reporting, Intake, Processing and Training Requirements (Effective date February 28, 2006) - Requirement to maintain documentation of Incident Management Training for all employees<br><br>Based on record review and interview, the facility failed to ensure required documentation of training on incident reporting per NMAC 7.1.13 requirements for 100% of staff. The findings are:<br><br>A. On 12/4/07 at 3:15 during review of the employee files it was noted the following required training documentation was missing:<br><br>- NMAC 7.2.13 regulatory training abuse, neglect and exploitation, and other reporting requirements documents or certificate of attendance with training dates<br><br>B. On 12/4/07 at 3:30 PM during interview with the Executive Director, he acknowledged the issue.<br><br>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 | A66 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 5707 | A. BUILDING _____ B. WING _____ | 12/04/2007 |

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|---|---|---|---|---|
| A66 | Continued From Page 12<br><br>Based on record review and interview, the facility failed to ensure that documentation of notice to family members and/or guardians regarding incident reporting information was in 100% of sampled resident files. The findings are:<br><br>A. On 12/4/07 at 2:00 PM during review of resident files, it was noted that none of the files reviewed had documentation of notification to family members/guardians regarding incident reporting.<br><br>B. On 12/4/07 at 3:30 PM during interview with the Executive Director, he acknowledged the issue.<br><br>Refer to NMAC 7.1.13.10(F) - Incident Reporting, Intake, Processing and Training Requirements (Effective date February 28, 2006) - Posting of Incident Management Information Poster<br><br>Based on observation and interview, the facility failed to ensure that the division Incident Management Information poster was posted as required. The findings are:<br><br>A. On 12/4/07 and throughout the course of the survey, it was noted that the 2008 Incident Management Information Poster was not seen posted anywhere in the facility.<br><br>B. On 12/4/07 at 3:30 PM during interview with the Executive Director, he acknowledged the issue. | A66 | VII. A. The Sunrise Senior Living Resident Agreement has Exhibit 7, Resident Grievance Procedure, (please see attached) which gives family members avenues in which to express complaints or concerns to the Executive Director, the Area Manager, the Area Vice-President of Operations, and to Sunrise Senior Living directly, as well as to The NM Department of Health Division of Health Improvement and to the NM Long Term Care Ombudsman. The ED will submit the Incident Management Reporting requirements to Sunrise Senior Living for their review and revision of the Resident Agreement.<br>B. All residents and/or their family members or responsible party will be given revised procedures when received by the community.<br>C. The ED will insure that all family members are aware of the new regulations during the move in process.<br>D. The process will begin by 1/05/08.<br><br>VIII. A. The community was unaware that an Incident Reporting poster was required. The ED will acquire posters and have them put up in both buildings. This will be done by 1/5/08. | |