STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2075	A. BUILDING _____ B. WING _____	C 10/04/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COTTONBLOOM ASSISTED LIVING COMMUNI	5525 COTTONBLOOM COURT LAS CRUCES, NM 88005

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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 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.	A36	attached response and subsequent documentation are attached herein	

Division of Health Improvement

Audrey Marion-Herdman-Hadley, MA TITLE Administrator (X6) DATE 10/26/07

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

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A36	Continued From page 1 (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: (1) The resident is capable of determining when the medication is needed. (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: (a) Symptoms that might indicate the use of the medication. (b) Exact dosage to be used. (c) The exact amount of medication to be used in a 24 hour period. (d) Directions as to what to do if the symptoms persist. (e) Possible interactions or side-effects that might occur. (f) Manufacturer's label information for directions if deemed adequate by the physician. I. The facility must report all medication errors to the physician. J. The facility shall develop and follow a written policy for unused, outdated, or recalled	A36		

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A36	Continued From page 2 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] This REQUIREMENT is not met as evidenced by: Surveyor: 21352 7.8.2.36 (C) Based on record review and interview, the facility failed to assure residents were receiving medications as ordered by the physician for 9 of 9 (1,2,3,4,5,6,7,8,9) sampled residents. The findings are: A. On 10/4/07, review of the medical record for R1 revealed she was admitted to the facility on 8/22/06. An Authroization to Assist with the Administration of Medications was signed on 8/22/06. 1. Review of the Medication Administration Record (MAR) 2/07 revealed a physician order for Fosamax 70 mg tablet. Take one tab by mouth once a week on Friday. The medication was signed off as given on 2/2/07 and 2/3/07. 2. Review of the Progress Notes for R1 dated 2/3/07 revealed "Gave wrong medication." 3. Review of a Facility-Physician Communication dated 2/3/07 revealed "FYI Resident was given fosamax 70 mg consecutive days Friday and Saturday. Was supposed to be given Friday only." a. Response from physician dated 2/6/07 "Hold dose as per physician." B. On 10/4/07, review of the medical record for R2 revealed she was admitted to the facility on 6/29/07. An Authorization to Assist with the Administration of Medications was signed on 6/29/07.	A36		

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A36	Continued From page 3 1. Review of the MAR for 8/07 revealed a physician order for Clonazepam 0.5 mg. Take 1 tablet by mouth at bedtime. The administration date of 8/20 is circled indicating the medication was not given. The administration date of 8/29/07 is also circled as not having been given. a. Review of the reverse side of the MAR revealed a notation dated 8/20/07 "Clonazepam 0.5 mg not given - out of med. b. Review of reverse side of the MAR revealed a notation dated 8/30/07 "Clonazepam 0.5 mg signed wrong place not given. 2. Review of the Community-Physician Communication dated 8/20/07 revealed "Resident missed evening dose of Clonazepam 0.5 mg." There was no communication for 8/30/07. C. On 10/4/07, review of the medical record for R3 revealed he was admitted to the facility on 7/6/07. An Authorization to Assist with the Administration of Medications was signed on 7/2/07. 1. Review of the MAR for 8/07 for R3 revealed a physician order for the following: a. Diovan 160/12.5 mg tablet. Take 1 tablet by mouth every day. b. Aspirin EC 325 mg tablet. Take 1 tablet by mouth every day. c. Prilosec 20 mg capsule. Take 1 capsule by mouth every morning. d. Lipitor 10 mg tablet. Take 1 tab by mouth at bedtime. e. Lotrel 10/20 mg capsule. Take 1 capsule by mouth at bedtime. f. Detrol LA 4 mg Capsule. Take 1 capsule by mouth at bedtime. g. Colace 100 mg capsule. One capsule by mouth at bedtime. 2. Review of the Community-Physician Communication dated 8/21/07 revealed, "This is	A36		

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A36	Continued From page 4 to inform you that a medication error has occurred. Resident was given wrong meds. Medications given were Claritin 10 mg, Prozac 20 mg, Cordarone 200 mg, Aspirin EC 81 mg." a. Review of the response from the physician revealed "Don't give him Lotrel 10 mg, Diovan, Detrol LA today. Tomorrow start him on all his medications." 3. Review of the MAR for 9/07 revealed "Diovan 160/12.5 mg was not given on 9/7 or 9/8/07." a. Review of the reverse side of the MAR revealed "9/6/07 Diovan signed in wrong spot med not given" and "9/7/07 Diovan signed in wrong spot med not given." D. On 10/4/07, review of the medical record for R4 revealed she was admitted to the facility on 5/2/02. A Consent to Assist with Medications was signed on 5/5/02. 1. Review of the MAR for R4 revealed a physician order for Trental 400 mg. Take 1 tab by mouth every 8 hours. 2. Review of the Progress Notes revealed "4/4/07 Late entry for 4/2/07. Trental not given at 100:00 PM. Med error." 3. Review of a Community-Physician Communication dated 4/4/07 revealed "Trental 400 mg not given on 4/2/07." E. On 10/4/07, review of the medical record for R5 revealed he was admitted to the facility on 5/4/06. An Authorization to Assist with the Administration of Medications as signed on 5/4/06. 1. Review of the MAR for 8/07 revealed a physician order for Prednisone 10 mg daily. 2. Review of a Community-Physician Communication revealed "This is to notify you that resident was given wrong medication due to	A36		

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A36	Continued From page 5 medication error. One tablet & a half was given 7.5 mg. Resident's MD order was to give 10 mg tablet of Prednisone." a. Review of a Community-Physician Communication dated 5/15/07 revealed "This is to advise you of medications found in room. Medications not given for unknown reason.." F. On 10/4/07, review of the medical record for R6 revealed he was admitted to the facility on 4/20/06. An Authorization to Assist with the Administration of Medications was signed on 4/20/06. 1. Review of the MAR for 7/07 revealed a physician order for Foadil 12 mcg capsule inhaler. One capsule by inhaler twice daily. a. Review of the reverse side of the MAR revealed "7/6/07 Foadil 12 mcg not in stock not given." 2. Review of a Community-Physician Communication dated 7/6/07 revealed "This is to inform you resident didn't get his Foadil (inhaler) today. Due to it not being in stock." G. On 10/4/07, review of the medical record for R7 revealed she was admitted to the facility on 9/27/06. An Authorization to Assist with the Administration of Medications was signed on 9/26/06. 1. Review of the MAR for 6/07 revealed "Vitamin D 400 IU tablets. Take 5 tablets by mouth daily." a. There is no notation on the reverse side of the MAR. 2. Review of a Community-Physician Communication dated 6/19/07 revealed "This is to inform you that resident was not given the full dose of Vitamin d 400 on 6/18/07. " H. On 10/4/07, review of the medical record for	A36		

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A36	Continued From page 6 R8 revealed she was admitted to the facility on 3/23/05. An Authorization to Assist with the Administration of Medications was signed on 3/23/05. 1. Review of the MAR for 3/07 revealed the following: a. Amphogel Liquid 30 M by mouth three times daily before meals started on 3/12/07 and changed on 3/14/07. b. Amphogel Liquid 30 ml by mouth once daily started on 3/15/07 and changed on 3/15/07. c. Amphogel Liquid 30 ml three times a day started on 3/15/05 at 4:00 PM. 2. Review of the Progress Notes for R8 dated 3/14/07 revealed, "Late entry error when reading order. put order for Amphogel 3 X a day when order changed from Mylanta II 3 times a day alternating with Amphogel three times a day to Amphogel once a day." 3. Review of a Facility-Physician Communication dated 3/14/07 revealed "When you ordered change in Mylanta II and Amphogel 3x a day alternating days, to Amphogel 1x a day, I misread MAR and gave Amphogel 3x a day." I. On 10/4/07, review of the medical record for R9 revealed she was admitted to the facility on 9/22/05. An Authorization to Assist with the Administration of Medications was signed on 3/22/06. 1. Review of the MAR for R9 dated 2/07 revealed a physician order for Folic Acid 1 mg tablet. Take 1 tablet by mouth every day except Wednesday. The medication was initialed as given on Wednesday 2/7/07. a. Review of a Facility-Physician Communication dated 2/12/07 revealed "This is to advise you Folic Acid was given on Wednesday when it should of been held. Found that dose was given on Friday, Folic Acid was	A36		

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A36	Continued From page 7 held to make up for it." There is no physician response. 2. Review of the MAR for R9 dated 7/07 revealed a physician order for Methotrexate 2.5 mg tablet. Take 6 tabs (15 mg) by mouth once a week on Sunday." a. Review of a Communication-Physician Communication dated 7/20/07 revealed "This is to inform you that resident was not given complete dose as ordered. Resident given 5 mg only instead of 15 mg of Methotrexate. " J. On 10/4/07 at 10:30 AM, during an interview with the Resident Care Coordinator, she was asked what was done after a medication error had been discovered. She stated the Medication Assistant (MA) are followed once a month during med pass. When asked what happened if the med error occurred after the MA had been followed, she stated an incident report was done. "Depending on if it's the first time or not, we do a verbal warning, then it progresses from there."	A36		