ORIGINAL

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 _____	03/19/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNRISE OF ALBUQUERQUE	4900 TRAMWAY RIDGE DRIVE NE ALBUQUERQUE, NM 87111

(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
A17	7 NMAC 8.2.17 Personnel 7.8.2.17 PERSONNEL: The adult residential care facility must have and implement written personnel policies. The personnel policies must address the following: A. Qualifications for all professional and non-professional disciplines. B. Staff conduct which must foster resident safety and well-being and must not be detrimental to resident care. C. Staff training, appropriate to staff responsibilities, including, at a minimum, an orientation and an on-going, but at least annual, program which includes: Fire Safety, First Aid, Safe Food Handling practices, Confidentiality of Records and Resident information, Infection Control, Resident Rights, Reporting Requirements for Abuse, Neglect, and Exploitation, Transportation Safety for Assisting residents and operating vehicles to transport residents and Providing Quality Resident Care based on current resident needs. D. Employee personnel records, including an application for employment, TB tests and certificates, training records, and personnel actions. [4-7-97; 7.8.2.17 NMAC - Rn & A, 7 NMAC 8.2.17, 8-31-00] This Requirement is not met as evidenced by: Refer to 7.8.2.17(C) - Required On Going Staff Training Based on record review and interview, the facility failed to ensure ongoing training for 20 of 20 facility employees. The findings are: A. On 3/17/09 during review of the personnel	A17	~~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. The Plan of Correction is prepared solely as a matter of compliance with federal and/or state law. **A17 7.8.2.17 PERSONNEL:** 1. Address how all violations identified in the official written report will be corrected. A. On 2/14/2008, First Aid Training was presented to all staff who attended the monthly staff meeting. Employees attending included staff # 5,7,13,14,15,16, & 19. (See attached sign-in sheet). On 3/25/09, Infection Control Training was presented to all staff who attended the monthly staff meeting. Employees attending included staff # 10,11,14,17 &18. On 2/12/09 and on 3/19/08, Resident Rights was presented to all staff who attended the monthly staff meetings. Employees attending on 2/12/09 included staff # 11, 18, 19. Sunrise Senior Living provides a required orientation to all new hires consisting of a week's formal training, and a minimum of three days shadowing. (See attached Orientation Curriculum) Training is to be completed no later than 30 days after hire. In addition, monthly training is now required for all staff to include State of NM and OSHA requirements annually. (Please see attached 2009 Schedule). 2. How the facility will identify other residents having the potential to be affected by the same deficient practice. Training of staff on a timely and on-going basis has the potential to affect all residents. The Sunrise Senior Living training program will insure that all staff is trained correctly and timely.	

Scanned 05-06-09

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

ASORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

4/27/09

RECEIVED MAY 2009 HEALTH FACILITY LICENSING & CERTIFICATION BUREAU

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION ORIGINAL	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	5707	A. BUILDING _____ B. WING _____	03/19/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNRISE OF ALBUQUERQUE	4900 TRAMWAY RIDGE DRIVE NE ALBUQUERQUE, NM 87111

(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
A17	Continued From Page 1 and facility records, it was noted that there was no documentation of current required training for the following: 1. First Aid - Staff # 3-9, 11-19 2. Confidentiality of Records - Staff #3-19 4. Infection Control - Staff #3, 6, 8-11, 13-18 5. Resident Rights - Staff #3, 4, 6, 9, 11, 17-19 6. Providing Quality Resident Care based on current resident needs - Staff #3-19 B. On 3/17/09 during an interview with the director, he acknowledged that documentation for the trainings was not available.	A17	3. How the facility will monitor its corrective action. All new hire training will be entered into Sunrise University registrar by the ED or the BOC within 30 days after hire. A copy of the transcript will be placed in their Personnel file. 4. Specify a date upon which the corrective action will be completed. All required training for new hires has been entered in the Sunrise University webpage and a copy placed in their Personnel file. All required state training has scheduled on a monthly basis and all staff have been advised that training is mandatory.	3/24/09
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	A35		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION: ORIGINAL	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	5707	A. BUILDING _____ B. WING _____	03/19/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNRISE OF ALBUQUERQUE	4900 TRAMWAY RIDGE DRIVE NE ALBUQUERQUE, NM 87111

(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
A35	Continued From Page 2	A35		

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.

(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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION ORIGINAL	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	5707	A. BUILDING _____ B. WING _____	03/19/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNRISE OF ALBUQUERQUE	4900 TRAMWAY RIDGE DRIVE NE ALBUQUERQUE, NM 87111

(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
A35	Continued From Page 3 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 7.8.2.35 A - Procurement, Labeling, and Storage Based on record review and interview, the facility failed to ensure that assistance was provided to 1 of 9 sampled residents (Resident #3) in obtaining the necessary medication that is required for the residents care. The findings are: A. On 3/18/09 during review of the March 2009 Medication Administration Record (MAR) for Resident #3, it was noted that the resident takes Metoprolol 25mg, 1/2 tablet in the evening, routinely. This medication was not available to the resident March 1st through March 10th 2009. The medication was noted on the back of the MAR as not available. B. On 3/18/09 during interview with Staff #17, she acknowledged the MAR showed that the medication was not available for the resident from March 1st through March 10th 2009.	A35	**A35 7 NMAC 8.2.35 Custodial Drug Permit** 1. Address how all violations identified in the official written report will be corrected. Resident was out of medication for nine days. Documentation in the Progress Notes noted that the physician had been notified, as well as the pharmacy. The pharmacy was working directly with the physicians office, bypassibng the facility. The concerns with the pharmacy has been addressed with the general manager, as well as with the physcian. 2. How the facility will identify other residents having the potential to be affected by the same deficient practice. All residents who use this pharmacy have the potential to be affected by this practice. 3. How the facility will monitor its corrective action. Medication Care Managers have been instructed to notify the Health Care Coordinator and/or the Wellness Nurse whenever medications are an issue with this pharmacy. The HC C and WC will monitor the MAR's on a weekly basis to insure that medications are on hand and/or ordered timely. 4. Specify a date upon which the corrective action will be completed. The violation was corrected by April 17, 2009.	4/17/09

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION ORIGINAL	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	5707	A. BUILDING _____ B. WING _____	03/19/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNRISE OF ALBUQUERQUE	4900 TRAMWAY RIDGE DRIVE NE ALBUQUERQUE, NM 87111

(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
A35	Continued From Page 4 Refer to 7.8.2.35 A (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. Based on observation and interview, the facility failed to ensure oxygen storage be in accordance with NFPA 99 (Standard for Healthcare Facilities) and the Compressed Gas Association. This deficient practice had the potential to affect 100% of residents and staff. The findings are: A. On 3/18/09 during a tour of the facility this surveyor observed 2 oxygen cylinders standing up beside a dresser in room 417, the oxygen was not secured. B. On 3/18/09 during an interview with the director, he acknowledged the oxygen was not secured.	A35	**A35 7 NMAC 8.2.35 Custodial Drug Permit** 1. Address how all violations identified in the official written report will be corrected. The two oxygen cylinders in room 417 were placed in a secure container at the time of survey. We have also contacted the DME provider and were informed that the carts to hold the oxygen were on back order. They have since been delivered. 2. How the facility will identify other residents having the potential to be affected by the same deficient practice. All residents who are on oxygen have had their rooms checked to insure that oxygen cylinders are contained in a secure container. All residents who receive oxygen are checked daily by care managers and have been advised to insure that all containers are secured in proper containers. 3. How the facility will monitor its corrective action. Care managers assigned to residents who use oxygen have been advised to check their rooms on each shift to insure that oxygen is safely secured. In addition, the Reminiscence Coordinator and Health Care Coordinator will check for secured oxygen on their daily rounds. The ED will spot check resident rooms during his rounds. 4. Specify a date upon which the corrective action will be completed. The violation was corrected at the time of survey.	3/18/09
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	A36		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION ORIGINAL	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	5707	A. BUILDING _____ B. WING _____	03/19/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNRISE OF ALBUQUERQUE	4900 TRAMWAY RIDGE DRIVE NE ALBUQUERQUE, NM 87111

(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
A36	Continued From Page 5	A36		

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.
(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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION ORIGINAL	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 5707	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/19/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNRISE OF ALBUQUERQUE	4900 TRAMWAY RIDGE DRIVE NE ALBUQUERQUE, NM 87111

(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
A36	Continued From Page 6 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 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: Refer to 7.8.2.36(C) - Not following physician's orders Based on record review and interview, the facility failed to ensure that no medications, including over the counter medications, PRN (when needed) medications, were started, changed or discontinued by the facility without an order by the physician and entered into the resident's record for 3 of 9 sampled residents.	A36		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION ORIGINAL	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 5707	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/19/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNRISE OF ALBUQUERQUE	4900 TRAMWAY RIDGE DRIVE NE ALBUQUERQUE, NM 87111

(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
A36	Continued From Page 7 The findings are: A. On 3/18/09 during review of the March 2009 MAR it was noted that Resident #1 did not receive the following medication per physician orders: a.) Namenda 10mg, not given March 15, 2009 b.) Depakote 125mg, not given March 15, 2009 c.) Risperdal 0.5mg, not given March 15, 2009 B. On 3/18/09 during review of the March 2009 MAR it was noted that Resident #2 did not receive the following medication per physician orders: a.) HCTZ 12.5mg, not given March 6 & 13, 2009 b.) Valproic Acid 250mg/5ml, not given March 15, 2009 C. On 3/18/09 during review of the March 2009 MAR it was noted that Resident #3 did not receive the following medication per physician orders: a.) Metoprolol 25mg, not given March 1-10, 2009 D. On 3/18/09 during interview with Staff #17, she acknowledged the medication errors. Refer to 7.8.2.36 (F)(8) - Medication Administration Record - staff initials	A36	**A36 7.8.2.36 Medications** 1. Address how all violations identified in the official written report will be corrected. A. (1) Resident #1 did receive her medications; however, the MAR was not initialed as given at the time of survey. (2) Resident #2 occasionally will refuse to swallow her medications. Hospice has been notified about this problem. (3) Resident #3 was out of medication during this period. The pharmacy was notified and the medication has been obtained. B. All Medication Care Managers have been instructed that on the first shift of each new month, they are to sign each page of the MAR with full signatures. C. All medication Care Managers have been instructed to notify the physician whenever medication is not given as ordered or there is any other type of med error. 2. How the facility will identify other residents having the potential to be affected by the same deficient practice. All residents have the potential to be affected by these practices. 3. How the facility will monitor its corrective action. The Health Care Coordinator and/or the Wellness Nurse will review and monitor the MAR's on a weekly basis. 4. Specify a date upon which the corrective action will be completed. The violations were corrected by April 24, 2009.	4/24/09

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION ORIGINAL	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	5707	A. BUILDING _____ B. WING _____	03/19/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNRISE OF ALBUQUERQUE	4900 TRAMWAY RIDGE DRIVE NE ALBUQUERQUE, NM 87111

(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
A36	Continued From Page 8 Based on record review and interview, the facility failed to have the name and corresponding initials of all caregivers trained to assist with medications listed on the back of the medication administration records (MAR). The findings are: A. On 3/18/09 during record review of resident March 2009 MAR's, it was noted that the names and corresponding initials of Staff, #17 and #18, caregivers who assist with medications, were not listed on all the Medication Administration Record key. B. On 3/18/09 during interview with Staff #17, she acknowledged that not all caregivers who assist with medication have their names and corresponding initials listed on the Medication Administration Record key. Refer to 7.8.2.36(I) - Reporting medication errors to the physician Based on record review and interview, the facility failed to ensure that all medication errors were reported to resident physicians for 3 of 9 sampled residents. The findings are: A. On 3/18/09 during review of the March 2009 MAR it was noted that Resident #1 did not receive the following medication per physician	A36		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION ORIGINAL	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 5707	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/19/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNRISE OF ALBUQUERQUE	4900 TRAMWAY RIDGE DRIVE NE ALBUQUERQUE, NM 87111

(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
A36	Continued From Page 9 orders: a.) Namenda 10mg, not given March 15, 2009 b.) Depakote 125mg, not given March 15, 2009 c.) Risperdal 0.5mg, not given March 15, 2009 B. On 3/18/09 during review of the March 2009 MAR it was noted that Resident #2 did not receive the following medication per physician orders: a.) HCTZ 12.5mg, not given March 6 & 13, 2009 b.) Valproic Acid 250mg/5ml, not given March 15, 2009 C. On 3/18/09 during review of the March 2009 MAR it was noted that Resident #3 did not receive the following medication per physician orders: a.) Metoprolol 25mg, not given March 1-10, 2009 D. On 3/18/09 during interview with Staff #17, she acknowledged the medication errors.	A36		
A59	7 NMAC 8.2.59 Fire Clearance & Inspections 7.8.2.59 FIRE CLEARANCE AND INSPECTIONS: A. Written documentation from the State Fire Marshall's office or Fire Prevention Authority having jurisdiction indicating a facility's compliance with applicable fire prevention codes shall be submitted to the Licensing Authority prior to issuance of a initial license. B. Each facility shall request from the local fire prevention authorities an annual fire inspection. If the policy of the local fire	A59	**A59 7.8.2.59 Fire Clearance and Inspections** 1. Address how all violations identified in the official report will be corrected. The City of Albuquerque Fire Marshall's office has been contacted bi-annually to request an annual inspection. However, no documentation has been kept regarding the contacts. The maintenance coordinator will continue to contact that office by telephone on a monthly basis until the inspection is completed. 2. How the facility will identify other residents having the potential to be affected by the same deficient practice. All residents have the potential to be affected by the violation. 3. How the facility will monitor its corrective action. The ED will check with the Maintenance Coordinator on a weekly basis until the inspection is completed. 4. Specify a date upon which the corrective action will be completed. The Maintenance Coordinator has begun contacting the City of Albuquerque Fire Marshall on April 17, 2009.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION ORIGINAL	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 5707	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/19/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNRISE OF ALBUQUERQUE	4900 TRAMWAY RIDGE DRIVE NE ALBUQUERQUE, NM 87111

(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
A59	Continued From Page 10 department does not provide for annual inspection of the facility, the facility will document the date the request was made and to whom and then contact licensing authorities. If the local fire prevention authorities do make annual inspections, a copy of the latest inspection must be kept on file in the facility. [7-1-64, 9-24-76, 7-11-86, 1-11-90, 4-7-97; 7.8.2.59 NMAC - Rn, 7 NMAC 8.2.59, 8-31-00] This Requirement is not met as evidenced by: 7.8.2.59 B. - FIRE INSPECTIONS Based on records review and interview, the facility failed to maintain documentation of an annual fire inspection. The findings are: A. On 3/17/09 review of facility records revealed no documentation of an annual fire inspection for 2008. B. On 3/17/09 during an interview with the director, he acknowledged that the facility failed to maintain documentation of an annual fire inspection.	A59		
A63	7 NMAC 8.2.63 Staff & Residient Fire & SafetyTraining 7.8.2.63 STAFF AND RESIDENT FIRE AND SAFETY TRAINING: A. All staff personnel of the facility must know the location of and be instructed in proper use of fire extinguishers and other procedures to be observed in case of fire or other emergencies. The facility should request the local fire prevention authority to give periodic instructions in the use of fire prevention and techniques of	A63		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION ORIGINAL	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	5707	A. BUILDING _____ B. WING _____	03/19/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNRISE OF ALBUQUERQUE	4900 TRAMWAY RIDGE DRIVE NE ALBUQUERQUE, NM 87111

(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
A63	Continued From Page 11 evacuation. B. Facility staff must be instructed as part of their duties to constantly strive to detect and eliminate potential safety hazards, such as loose handrails, frayed electrical cords, blocked exits or exit-ways, and any other condition which could cause burns, falls, or other personal injury to the residents or staff. C. Each new resident must upon being accepted into the facility be given an orientation tour of the facility to include, but not be limited to, the location of the exits, fire extinguishers, and telephones, and shall be instructed in action to be taken in case of fire or other emergency. D. Fire Drills: The facility must conduct at least one (1) fire drill each month: (1) Fire drills must be held at different times of the day. (2) The fire alarm system or detector system in the facility shall be used in the conduct of fire drills. (3) In the conduct of fire drills, emphasis must be placed upon orderly evacuation under proper discipline rather than upon speed. (4) A record of fire drills held must be maintained on file in the facility. Such record must show date and time of the drill, number of personnel participating in the drill, any problem noted during the drill and the evacuation time in total minutes. (5) The local fire department should be requested to supervise and participate in fire drills. [9-24-76, 7-11-86, 1-11-90, 4-7-97; 7.8.2.63 NMAC - Rn, 7 NMAC 8.2.63, 8-31-00] This Requirement is not met as evidenced by: Refer to 7.8.2.63 (A) - Train on fire and safety training	A63		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
ORIGINAL	5707	A. BUILDING _____ B. WING _____	03/19/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNRISE OF ALBUQUERQUE	4900 TRAMWAY RIDGE DRIVE NE ALBUQUERQUE, NM 87111

(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
A63	Continued From Page 12 Based on record review and interview, the facility failed to ensure ongoing fire and safety training for 11 of 20 facility employees. The findings are: A. On 3/17/09 during review of employee records, it was noted that there was no evidence of current required training in fire safety for Staff #3, #5, #6, #7, #8, #9, #15, #16, #17, #18, and #19. B. On 3/17/09 during an interview with the director, he acknowledged that documentation of annual fire safety training was not available. . Refer to 7.8.2.63 D. (3-4) Based on record review and interview, the facility failed to, in the conduct of fire drills, emphasize orderly evacuation and maintain a record of the evacuation time in total minutes. The findings are: A. On 3/18/09 at 1:30 pm review of monthly fire drill records for 2008 and 2009 revealed that residents are not evacuated and evacuation time in total minutes was not noted. B. On 3/18/09 at 1:30 pm during an interview with the director, he acknowledged that the fire drills do not include an evacuation of the residents from the building.	A63	**A63 7.8.2.63 Staff and Resident Fire and Safety Training** 1. Address how all violations identified in the official report will be corrected. Annual Fire Safety training was presented at the Town Hall meeting and staff # 5, 15, and 16 attended. Annual Fire Safety training was presented on 1/22/09. A make-up Fire Safety training was given on 2/06/09 for Reminiscence and staff # 5, 6, and 9 attended. 2. How the facility will identify other residents who have the potential to be affected by the same deficient practice. All residents have the potential to be affected by the practice of staff not being training in annual fire safety practices. 3. How the facility will monitor its corrective action. All staff have been advised that all State mandated training is required on an annual basis. Training is scheduled monthly at the Staff meeting. Make up sessions of the training are held throughout the month for those who were unable to attend. 4. Specify a date upon which the corrective action will be completed. All required training for new hires has been completed and entered in the Sunrise University webpage and a copy placed in their personnel file. All required state training is scheduled on a monthly basis and all staff have been advised that training is mandatory.	ON-GO 10/1

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION ORIGINAL	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 5707	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/19/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNRISE OF ALBUQUERQUE	4900 TRAMWAY RIDGE DRIVE NE ALBUQUERQUE, NM 87111

(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 13	A66		
A66	7 NMAC 8.2.66 Related Regulations & Codes 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: A. Health Facility Licensure Fees and Procedures, New Mexico Department of Health 7 NMAC 1.7 (10-31-96). B. Health Facility Sanctions and Civil Monetary Penalties, New Mexico Department of Health, 7 NMAC 1.8 (10-31-96). 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] This Requirement is not met as evidenced by: Refer to NMAC 7.1.12.8(a) Employee Abuse Registry (Effective January 1, 2006) - Care Provider requirement to inquire of registry whether the individual under consideration for employment is listed on the registry. Based on record review and interview, the facility failed to maintain documentation that the Employee Abuse Registry (EAR) database was checked prior to offer of employment for 3 of 20 sampled employees. The findings are: A. On 3/17/09 during review of employee records, it was noted that employed staff did not have documentation on file that search of the EAR database using the individual's identifying information was checked prior to hire, as required, for Staff #1, #2 and #20.	A66	**A 63 7.8.2.63 Staff and Resident Fire and Safety Training** 1. Address how all violations identified in the official report will be corrected. An orderly evacuation of the neighborhood will be conducted during the fire drill on the first and second shifts. Documentation of the total time of the drill will be noted on the Fire Drill Evaluation Check List. 2. How the facility will identify the other residents who have the potential to be affected by the same deficient practice. All residents have the potential to be affected. 3. How the facility will monitor its corrective action. The maintenance coordinator and the executive director will be responsible for monitoring fire drills. 4. Specify a date upon which the corrective action will be completed. All future fire drills will have the documentation of the evacuation and total time of drill on the Evaluation Check List.	ON-GOING

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
ORIGINAL	5707	A. BUILDING _____ B. WING _____	03/19/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNRISE OF ALBUQUERQUE	4900 TRAMWAY RIDGE DRIVE NE ALBUQUERQUE, NM 87111

(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 14 B. On 3/17/09 during an interview with the director, he acknowledged the documentation of the EAR check done prior to hire was not on file for the stated employees. Refer to NMAC 7.1.13.10(B) Incident Reporting, Intake, Processing and Training Requirements (Effective date February 28, 2006) - Requirement to train employees annual. Based on record review and interview, the facility failed to ensure required training was conducted within the time frames set in accordance with regulations in the incident reporting, intake, processing and training requirements (NMAC 7.1.13, effective February 28, 2006) for 20 of 20 (Staff #1-20) sampled employees. The findings are: A. On 3/18/09 during review of personnel files, it was noted that the required annual training for Incident Management was not among administrative paperwork. B. On 3/18/09 during interview with the director, he acknowledged that documentation of the training was not available, and the training was not done annually.	A66	**A66 7.8.2.66 Related Regulations and Code** 1. Address how all violations identified in the official report will be corrected. A. This was corrected at the time of survey. All future new hires will have the EAR database checked and a copy placed in their personnel file prior to hire. B. The required annual training of Incident Reporting was held on January 17, 2008 at our regualr monthly staff meeting. This training was not entered into staff training binder. 2. How the facility will iodentify other residents having the potential to affected by the same deficient practice. Training of staff on as timely and on-going basis has the potential to affect all residents. The Sunrise Senior Living training program will insure that all staff is trained correctly and timely. 3 How the facility will monitor its corrective action. All new hire training will be entered into Sunrise University registrar by the ED or the BOC within 30 days after hire. All required state training has been scheduled on a monthly basis and all staff have been advised that training is mandatory. A copy of the transcript will be placed in their Personnel file. 4. Specify a date upon which the corrective action will be completed. All required training for new hires has been entered in the Sunrise University webpage and a copy placed in their personnel file. All required state training has been scheduled throughout the year and all staff have been advised that train ing is mandatory.	ON-GOING