Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	5831	A. BUILDING ______ B. WING ______	C 04/19/2005

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTWIND HOUSE ASSISTED LIVING	6600 LOS VOLCANES NW ALBUQUERQUE, NM 87121

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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
A22	7 NMAC 8.2.22 RESIDENT RECORDS 7.8.2.22 RESIDENT RECORDS: A. RESIDENT RECORDS, CONTENTS: A record for each resident shall be maintained with specific information required. Entries in each resident's record shall be legible, dated, and authenticated by the signature of the person making the entry. Resident records must include: (1) Admission records as set out in Section 7.8.2.21 NMAC: (2) Within five (5) days of admission: (a) An executed admission agreement. (b) A completed resident assessment form. (c) Any available, admission physical examination report by a licensed health care professional, which may include all discharge information from another facility. When admission follows within thirty (30) days discharge from an acute care hospital, the hospital history and physical report, and the hospital discharge summary may serve as an admission physical. (d) Names, addresses, relationship, and phone numbers of family members, and where appropriate, guardians, agents, and any surrogate decision makers. (3) Within thirty (30) days of admission: (a) A admission physical examination report by a licensed health care professional if an examination report was not available within five (5) days of admission. (b) Resident's name, age, recent photograph, social security number, marital status, date of birth, sex, address prior to admission, religion (optional), personal physician, dentist, social history and designated representative or other emergency contact person, language spoken and understood, legal documentation relevant to commitment and/or guardianship status, present medications, and	A22		

Division of Health Improvement

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Maria R Lepu [signature]
TITLE: Administrator
(X6) DATE: 5-14-05

MAY 23 2005

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 5831	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED C 04/19/2005
NAME OF PROVIDER OR SUPPLIER: **WESTWIND HOUSE ASSISTED LIVING**	STREET ADDRESS, CITY, STATE, ZIP CODE: **6600 LOS VOLCANES NW ALBUQUERQUE, NM 87121**		

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A22	Continued From page 1 diet required. (c) Any amendments to the admission agreement. (d) The current completed resident assessment form. (e) A completed and current individual service plan. (f) Entries by direct care staff, appropriate health care professionals, or others authorized to care for the resident. Entries shall be dated and signed by the person making the entry and shall include significant information related to the individual service plan. (g) Entries providing a written account of all accidents, injuries, illnesses, medical and dental appointments, any problems or improvements observed in the resident, any condition that would indicate a need for alternative placement or medical attention, and entries reflecting appropriate follow-up. The maintenance of such written record in the resident record may be by copy of an incident/accident report, if the original incident/accident report is maintained elsewhere by the facility. (h) A medication record: Medications administered by licensed personnel and/or staff assisting with medications to include: listing all currently ordered medications by name, dosage, administration times; documenting by medication name, dosage, date, and time, each medication administered, with the initials of the individual who administered or assisted with the medication; documentation of errors, omissions, and side-effects of medications; and written consent by resident or guardian for staff to assisting with medications. (i) Date, time and progress note of health services provided by any contract agency. (j) Unless included in the admission	A22		

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A22	Continued From page 2 agreement, a separate written agreement between the facility and the resident relating to the resident's funds, in accordance with the facility's policy and procedures. (k) Transfer forms completed, signed, and provided to accepting facility when resident is transferring to a hospital or another health care facility. (l) Documentation of disposition of the resident's personal effects and money or valuables deposited with the adult residential care facility, upon death or transfer. B. RESIDENT RECORDS, MAINTENANCE: (1) Resident records shall be maintained and stored in an organized, accessible and permanent manner. (2) The facility shall establish a policy for maintaining, and confidentiality of resident records, including the authorized release of resident records. (3) Resident records must be maintained by the facility against loss, destruction, and unauthorized use for a period of not less than three (3) years from the date of discharge. (4) There must be a policy and procedure in place for record retention in the event of facility closure. [7-1-64, 9-15-70, 5-26-72, 9-24-76, 7-11-86, 1-11-90, 4-7-97, 7.8.2.22 NMAC - Rn 7 NMAC 8.2.22, 8-31-00] This REQUIREMENT is not met as evidenced by: Surveyor: 20402 Refer to 7.8.2.22 Part A. (h) Based on record review and interview, the facility failed to maintain documentation of written consent for assisting with medications for 1 of 3	A22		

Allana R Lopez

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A22	Continued From page 3 residents (R#1). The findings are: A. On 4/19/05 at 10:30 A.M. During record review of resident (R#1's) chart, it was revealed that there was no documentation of a medication consent form for staff to assist with medications. B. On 4/19/05 During review of resident (R#1's) Individual Service Plan, it was noted that resident is unable to administer her own medications. The Individual service plan states: have resident or responsible party sign authorization for staff to assist with medications. C. On 4/19/05 at 10:30 A.M. During interview with the facility administrator, she stated "I don't see it here".	A22 A22	1. Consent forms for staff to assist with medications are now signed and in all resident charts. 2. All resident charts have been audited and all that receive assistance with medications by the staff have a signed consent. 3. The medication consent form is now in the admission packet to discuss and have signed with the resident and family upon admission to the facility. 4. Completion Date 05/27/05	
A23	7 NMAC 8.2.23 FAC. REPORTS,RECS.,P & PS & RULES 7.8.2.23 FACILITY REPORTS/RECORDS/POLICIES AND PROCEDURES/ AND RULES: A. REPORTS AND RECORDS: Each facility must keep the following reports, records, and policy and procedures on file at the facility and make them available for review upon request of the Licensing Authority: (1) Fire Inspection Report. EXCEPTION: Adult residential care facilities with three (3) or fewer residents are not required to have fire inspection reports. (2) Copy of the last survey conducted by the Licensing Authority, adverse actions or appeals thereto, and complaints. (3) Copy of the latest survey from Environmental Health Authority (if applicable) regarding kitchen and food management and, if private sewage disposal, and private waste disposal. EXCEPTIONS: Adult residential care facilities with three (3) or fewer residents are not	A23		

Mara R Leyba

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A23	Continued From page 4	A23		

required to be inspected by Environmental Health Authority. Facilities exempted by the Environmental Health Authority having jurisdiction, are not required to have a survey on file provided the exemption letter is on file.

(4) TB test results of staff or any of their family members living in the facility.

(5) One (1) month of menus planned and as served.

(6) Record of fire drills: A record of all fire drills conducted at the facility. EXCEPTION: Adult residential care facilities with three (3) or fewer residents are not required to hold or record fire drills.

(7) Written emergency plans and policies and procedures for medical emergencies, power failure, fire or natural disaster. Such plans shall include evacuation, persons to be notified, emergency equipment, evacuation routes and refuge areas, responsibilities of personnel.

(8) Licensing regulations: A copy of these regulations (Requirements for Adult Residential Care Facilities, 7.8.2 NMAC).

(9) Custodial Drug Permit: A valid Custodial Drug Permit issued by the State Board of Pharmacy for those facilities licensed pursuant to these regulations. EXCEPTION: Adult residential care facilities with only one (1) resident are not required to have a custodial drug permit.

(10) Vaccination of pets in the facility.

(11) Staff training.

(a) At orientation and on-going.

(b) Appropriate to staff responsibilities. (Assistance with medications, dietary, environmental...)

(c) Fire safety.

(d) First aid.

(e) Safe food handling practices.

(f) Confidentiality of records and

Maria R Lopez

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A23	Continued From page 5	A23		

resident information.

(g) Infection control (including universal precautions and linen handling).

(h) Resident rights.

(i) Providing Quality Resident care based on current resident need.

(j) Reporting requirements for Abuse, Neglect or Exploitation.

(12) A copy of License.

(13) Employee personnel records, including an application for employment, TB certificates, training records, and personnel actions.

(14) A copy of all WAIVERS/VARIANCES granted by the Licensing Authority.

(15) A copy of the floor plans as approved for licensure.

B. RULES: Prior to placement in or admission to a facility, a prospective resident or his/her representative shall be given a copy of the facility rules. Each facility shall have written rules pertaining to but not limited to the following:

(1) The use of tobacco and alcohol.

(2) The use of the telephone.

(3) Operation of television, radio, and stereo.

(5) Use and safekeeping of personal property.

(6) Meals.

(7) Use of common areas.

(8) Electric blankets or appliances used by residents.

C. POLICIES AND PROCEDURES: All facilities shall have written policies and procedures covering the following areas:

(1) Actions to be taken in case of accidents or emergencies, (e.g., gas leaks, injuries, transportation, medications,...).

(2) Method of keeping informed when residents go outside of the facility (e.g., sign-out

Maria R Lopez

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A23	Continued From page 6 sheets). (3) The handling or resident's funds, if the facility provides such services. (4) Reporting of incidents, including abuse, neglect, and exploitation. (5) Handling of complaints. (6) Staff and resident fire and safety training. (7) Smoking. (8) The facility's bed hold policy. (9) Admission agreement. (10) Admission records. (11) Resident records. (12) Program Narrative. (13) Information about the resident's right under New Mexico Law to make decisions regarding health care, including the right to make advance directives. (14) Personnel policies. (15) Identifying and safeguarding resident possessions. (16) Securing medical assistance if a resident's own physician is not available. (17) NOTE FOR MATERNITY SHELTERS ONLY: In addition to the required policy and procedure topics listed above, Maternity Shelters shall have written policies and procedures regarding infant formula, feeding and equipment, and laundering of infant linen and diapers. (18) Staff training for employees who provide assistance to residents with boarding or alighting from motor vehicles. (19) Staff training for employees who operate motor vehicles to transport residents. [7-1-64, 9-15-70, 5-26-72, 9-24-76, 7-11-86, 1-11-90, 4-7-97; 7.8.2.23 NMAC - Rn & A 7 NMAC 8.2.23, 8-31-00] This REQUIREMENT is not met as evidenced by:	A23		

Maria n Lopez

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A23	Continued From page 7 Surveyor: 20402 Refer to 7.8.2.23 Subsection C (14) Based on Review of the facility's Policies and Procedures and staff interviews, the facility failed to follow policy and procedures that resulted in the neglect of 1 of 3 residents (R#1). The findings are: A. On 4/19/05 During review of the facilities policies and procedures for Morning Assistance, it was revealed that: Policy- Morning assistance is given to a resident in a manner that recognizes individual needs and encourages the resident to as much on their own as possible. Procedures- Confirm level of assistance to be given based on individual service plans. Verbally remind and encourage the resident to begin morning tasks. Provide verbal direction or hands-on assistance to uise the bathroom, wash hands, face, peri-area, etc. Inform the resident care coordinator and administrator of any change in the level of assistance required by the resident. Review of the Resident #1s (R1) Individual Service Plan revealed that staff was to give resident R1 reminders for time for meals, bathing, grooming, activities and appointments. In interview on 4/20/05 at 8:13 AM staff (E2 and E3) confirmed that they did not go and check on the resident at any time during the day. During interview on 4/18/05 at 11 AM the facility administrator confirmed that employee #R7 did not check on resident R1 even though she never appeared for her daily medications.	A23 A23	1. Employees E2 and E3 were terminated for not following facility policies regarding resident care and supervision. Employee E7 was suspended for 5 days for not following up with resident when she did not appear for her medications. 1:1 inservice training on policies and procedures was given with the above employees. A staff meeting was held for all employees and discussion was had by all on how to check residents, how often and what to report to the supervisor. 2. All staff will be formally inserviced on resident rights, adherence to facility policies and resident care by the facility nurse consultant on May 27, 2005. On-going, classes pertaining to resident care, resident rights, medication assistance, Vital Signs and	
A33	7 NMAC 8.2.33 REPORTING OF INCIDENTS 7.8.2.33 REPORTING OF INCIDENTS: A. The facility must insure that all suspected cases or known incidents of resident abuse,	A33		

Allana K Lopez

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A33	Continued From page 8 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. B. The facility is responsible for documenting all incidents, within five (5) days of the incident, and having on file, the following: (1) A narrative description of the incident. (2) Results of the facility's investigation. (3) The facility action, if any. [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] This REQUIREMENT is not met as evidenced by: Surveyor: 20402 Refer to 7.8.2.33 Based on Record Review and interview, the facility failed to report an incident of abuse, neglect, and missed medications for 1 of 3 residents (R#1) to the Licensing Authority and Adult Protective Services by the next business day. The findings are: A. On 4/18/05 During record review, there was no documentation of an incident report regarding the abuse and neglect of one resident (R#1) on 4/11/05. Record Review also revealed there to be no incident report for 4 medications (Lexapro 20 mg, Hyzaar 50/12.5 mg, Plendil, and L-Thyroxine) that were to be administered at 8:00 A.M. on the morning of 4/11/05 and 1 medication (Nabumetone 500 mg tab) that was to be given	A33	other areas of CNA training requirements are going to be taught at the facility for 4 hours, weekly, for all direct care staff beginning June 2005 by the facility nurse consultant. 3. Periodic rounds of resident rooms and resident care will be made by the Administrator and Resident Care Coordinator. 4. Completion Date 05/27/05	

Illiana K Lupe

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A33	Continued From page 9 with breakfast. Review of the medication record revealed these 5 medications were not administered to resident (R#1) on the morning of 4/11/05. B. On 4/15/05 at 2:33 P.M. During interview with the facility administrator, she stated that she faxed a report only to Adult Protective Services on 4/11/05. C. On 4/22/05 at 11:53 A.M. During interview with the facility administrator, she stated that she did not fax an incident report to Licensing and Certification regarding the death of resident (R#1) on 4/11/05. When the surveyor asked why no incident report was sent to Licensing and Certification, the facility administrator stated that "It's what I understood in the regulations" as "I was to send it to Adult Protective Services." D. On 4/22/05 at 11:53 A.M. During interview with the facility administrator, she stated she didn't think a report was filled out regarding the 5 medications that were not given on the morning of 4/11/05. Record Review of Resident (R#1's) medical chart showed there to be no documentation of any other incident reports. E. On 4/22/05 During review of facility policies and procedures for reporting of incidents, including abuse, neglect, and exploitation, it was noted that Adult protective services and state licensing will be notified of certain incidents.	A33 A33	1. The Administrator and Resident Care Coordinator have reviewed the policies and procedures and been made aware that incidents are to be reported to DOH Licensing and Certification, APS and Ombudsman within 24 hours. 2. The Administrator and Resident Care Coordinator have asked all staff to report to them any incidents regarding residents, visitors or employees on a daily basis. 3. The Administrator and Resident Care Coordinator will monitor resident care and situations and report any injury, ER visit, hospitalization or death to DOH Licensing and Certification, APS and Ombudsman. 4. Completion Date 05/27/05	
A34	7 NMAC 8.2.34 RESIDENT RIGHTS 7.8.2.34 RESIDENT RIGHTS: All licensed facilities shall be aware of, protect, and enhance the rights of all residents. A. Prior to admission to a facility, a resident	A34		

Marie R Lopez

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A34	Continued From page 10	A34		

and/or legal representative shall be given a written description of the legal rights of the residents translated into another language, if necessary, to meet the residents understanding.

B. If the resident is incapable of understanding his/her legal rights, and if he/she has no legal representative, then the licensee shall also give a written copy of the resident's legal rights to one of the following persons, in this order of priority:

(1) the resident's spouse;
(2) any of the resident's adult children;
(3) either of the resident's parents;
(4) any relative the resident has lived with for six or more months before admission;
(5) a person who has been caring for, or paying benefits on behalf of the resident;
(6) a placing agency; or
(7) any other person, e.g., Ombudsman.

C. These resident rights and the telephone number for the Ombudsman Program shall be posted in a conspicuous place in the facility:

D. The facility, to protect resident rights must:

(1) Treat all residents with courtesy, respect, dignity and compassion.
(2) To the extent that resident required services fall within the scope of the facilities program, avoid discrimination in admission or services because of a resident's age, race, religion, physical or mental disability, or nationality.
(3) Furnish residents written information about all services provided by the facility and their costs, and advance written notice of any changes.
(4) Assure that residents have a safe and sanitary living environment.
(5) Provide humane care.
(6) Assure the resident's rights to privacy

Mana R Lopez

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A34	Continued From page 11 in medical care, including privacy during medical examinations, consultations and treatment; and protect the confidentiality of the resident medical records. (7) Protect and assure the resident's 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. (8) Assure the resident's right to communicate privately and freely with any person, including private telephone conversations and private correspondence; and assure the resident's right's to receive visits from family, friends, lawyers, ombudsmen and community organizations. (9) Prohibit the use of any and all physical and chemical restraints. (10) Assure the residents are free from physical and emotional abuse and neglect. (11) Assure that all residents are free from financial abuse and exploitation by facility staff and/or management. (12) Consistent with the resident's health, abilities and security, assure the right of the resident to freely participate in religious, social, community and other activities; and freely associate with persons in and out of the facility. (13) Permit the residents to leave the facility freely and return without unreasonable restriction. (14) Prevent unjustified room transfers or discharge from this facility. (15) Use care and management practices that foster social interaction and avoid practices that unnecessarily result in social isolation. (16) Provide services consistent with informed consent. (17) Assure that all residents may voice	A34		

Maria R Lopez

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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
A34	Continued From page 12 grievances to the facility staff, public officials, the ombudsmen or any other person, without fear of reprisal or retaliation. (18) Promptly address and resolve resident complaints. (19) Foster resident participation and understanding in the development, review and modification of the resident's plan for care and treatment. (20) Respect a resident's choice of doctor, pharmacist and other health care provider. (21) Respect a resident's medical treatment decisions and advance directives, such as living wills and durable powers of attorney for health care. (22) Respect a resident's right to keep and use personal possessions without loss or damage. (23) Allow each resident to manage and control the resident's personal finances to the extent that the resident is able, and provide to every resident a written record of all financial arrangements and transactions involving that resident's funds. (24) Allow residents to freely organize and participate in a resident association that may recommend changes in the facility's policies, services and management. (25) Require no resident to work for the facility. (26) Consult with the incapacitated resident regarding his/her care, regardless of the involvement of a guardian or surrogate decision maker. (27) Assure the involvement in, and consent of, an incapacitated resident's guardian or surrogate decision maker in the resident's care. E. The resident's rights shall not be	A34		

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	5831	A. BUILDING ____ B. WING ____	C 04/19/2005

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restricted unless the resident agrees to such a restriction, and unless this restriction is described in detail in his/her individual service plan.
[9-24-76, 7-11-86, 1-11-90, 4-7-97; 7.8.2.34 NMAC - Rn, 7 NMAC 8.2.34, 8-31-00]
This REQUIREMENT is not met as evidenced by:
Surveyor: 20402
Refer to 7.8.2.34 Subsection D (1), (5), (10). Also 7.8.2.7 BB "Neglect" (1-3)

Based on record review, and staff interviews, the facility failed to protect the rights, and assure that 1 of 3 residents (R#1) were free from physical, emotional abuse, and gross neglect. The findings are:

A. On 4/18/05 at 9:45 A.M. During interview with the facility administrator, she stated that:
1. On 4/11/05 "she didn't know how long resident (R#1) had been deceased".
2. During the change of shift between day shift employees (E#2, E#3) and
oncoming 3p.m.-11 p.m. shift employee (E#4), "nothing was mentioned about resident (R#1) or any indication she may have been dead".

B. On 4/20/05 at 3:15 P.M. during interview, employee E#2 stated stated that when she came on to work at 5:45 A.M. on 4/11/05, she went and got the laundry that was outside resident (R#1's) door and that she was supposed to check on resident (R#1), that she at 6:00 A.M. went into resident (R#1's) room and just peeked into her room and she appeared to be sleeping so she left. Employee (E#2) also stated that she did not talk to resident R#1 at all on 4/11/05. Employee #2 confirmed that she initialed SB (standby) on the monthly worksheet because the resident was independent, not because she had observed the

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NAME OF PROVIDER OR SUPPLIER: WESTWIND HOUSE ASSISTED LIVING	STREET ADDRESS, CITY, STATE, ZIP CODE: 6600 LOS VOLCANES NW ALBUQUERQUE, NM 87121		

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A34	Continued From page 15 normal. Employee confirmed that at 4:00 P.M. on 4/11/05 employee (E#4) went into resident (R#1's) room and knocked on the door and said "It's time to eat". Employee (E#4) stated she opened the door and called resident (R#1's) name and when she didn't answer, she walked over to her bed and called her name again. 2. Employee (E#4) stated that there was no response and resident (R#1) looked like she was sleeping. Employee (E#4) stated she touched resident (R#1's) arm and it was cold and she checked a pulse and did not feel one.	A34 A34	1. Employees E2 and E3 were terminated for not following facility policies regarding resident care and supervision. Employee E7 was suspended for 5 days for not following up with resident when she did not appear for her medications. 1:1 inservice training on policies and procedures was given with the above employees. A staff meeting was held for all employees and discussion was had by all on how to check residents, how often and what to report to the supervisor. Walking rounds between shifts was also discussed and will be enforced. 2. Inservice training follow up and reinforcement of above discussions is scheduled for 5/27/05 by the facility nurse consultant. On-going, classes pertaining to resident care, resident rights, medication	
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.	A36		

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A34	Continued From page 14 actions and that she circled "R" for refused meals even though she had not spoken with the resident. C. On 4/20/05 at 8:13 A.M. during phone interview, the day shift caregiver (E#3) stated that "I never reminded myself to go and check on her (R#1)" and confirmed that she had not directly observed her or interacted with resident #R1 during the day. Employee #E3 confirmed that she was aware that R#1 did not go to meals during the day. D. On 4/18/05 During record review of resident (R#1's) individual service plan, it was noted that staff was to be giving resident (R#1) reminders for time for meals, bathing, grooming, activities, and appointments. The individual service plan also stated that resident (R#1) will be safe and cared for with reminders and assistance from staff. E. On 4/18/05 ar 11:00 A.M. during interview with the facility administrator, she stated that employee (E#7) was supposed to administer resident (R#1's) 8:00 A.M. medications to her on the morning of 4/11/05 and did not ever go back to her room to check on her when she did not arrive for the medications which she was to receive. 1. The facility administrator stated that when she spoke to employee (E#7) and asked if the medications were given, employee (E#7) stated "I forgot to go back and check on her". F. On 4/20/05 at 8:45 A.M. During phone interview with employee (E#4), she stated that she came on to work on the 3-11 p.m. shift on 4/11/05 and she was told everything was fine and	A34	assistance, Vital Signs and other areas of CNA training requirements are going to be taught at the facility for 4 hours, weekly, for all direct care staff beginning June 2005 by the facility nurse consultant. 3. The administrator and Resident Care Coordinator will periodically make walking rounds with the employees at change of shift to assure that an accurate report is given and received regarding each resident. 4. Completion Date 05/27/05	

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D. The facility must have on the premises, medication reference material that contains information relating to drug interactions and side-effects.

E. Medications prescribed for one resident shall not be used for another resident.

F. The facility shall have a Medication Administration Record (MAR) documenting medications administered to residents, including over-the-counter medications. This documentation shall include:

(1) Name of resident.
(2) Date started.
(3) Drug product name.
(4) Dosage and form.
(5) Strength of drug.
(6) Route of administration (e.g. "by mouth").
(7) How often medication is to be taken.
(8) Time taken and staff initials.
(9) Dates when the medication is discontinued or changed.
(10) The name and initials of all staff administering medications.

G. Any medications removed from the pharmacy container or blister pack must be given immediately and documented by the person assisting.

H. PRN Medications: The use of PRN medications must be closely monitored and supervised by the facility and is based on one or more of the following conditions:

(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

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A36	Continued From page 17 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: Surveyor: 20402 Refer to 7.8.2.36 Subsection B, C Based on record review and interview that facility failed to have documentation of written consent for staff to assist with medications. The facility also failed to administer medications at the prescribed time, and failed to follow a physician's order for daily blood pressure checks for 1 of 3 residents (R#1). The findings are: A. On 4/19/05 at 10:30 A.M. During record review, it was noted that there was no documentation of a consent form for staff to be assisting resident (R#1) with medications. During interview with the facility administrator at 10:30 A.M., she stated "I don't see it here". B. On 4/19/05 During record review it was noted that a physician's order was written on 12/6/04 for	A36 **A36**	**1. All resident records have signed medication assistance consent forms. Employee E7 was suspended for 5 days and reprimanded for failing to assist with medications as ordered. A staff meeting was held regarding following physician orders pertaining to medication assistance and taking blood pressures and other vital signs as ordered.** **2. The Administrator and Resident Care Coordinator have checked physician orders regarding medication assistance and Vital Signs and reprimanded staff if found not adhering to the physician orders. A5/27/05 inservice training by the facility nurse consultant is being held to discuss these issues as well as many others.** **3. The Administrator and Resident Care Coordinator will periodically monitor**	

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A36	Continued From page 18 "Lexapro 20 mg one each morning for depression", Plendil 10 mg one a day each morning, Hyzaar 50/12.5 mg one in AM, and L-Thyroxine .05 mg one in AM. Another physician's order was written on 3/9/05 for "Nabumetone 500 mg BID with food". C. On 4/19/05 During record review, it was noted that on that morning of 4/11/05 on the 7A.M.-3P.M. shift, no scheduled medications were administered. At 8:00 A.M. on 4/11/05 Resident (R#1) was supposed to be given Lexapro 20mg, Hyzaar 50/12.5 mg, Plendil, L-Thyroxine 0.05 mg. Resident (R#1) was also supposed to be given Nabumetone 500 mg 1 tablet with breakfast. D. On 4/19/05 During record review of resident (R#1's) medication record, it was noted that the initials of "RM" with a cirlce around were written on the morning of 4/11/05. E. On 4/18/05 at 11:00 A.M. During interview with the facility administrator, she stated that employee (E#7) was suspended for 5 days becasue employee (E#7) did not ever go back to resident (R#1's) room to check on her knowing that the medications were to be given at 8:00 A.M. and resident (R#1) wasn't around. 1. The facility administrator stated that when she spoke to employee (E#7) about this, employee (E#7) stated "I forgot to go back and check on her" 2. On 4/18/05 at 2:30 P.M. the facility administrator stated that resident (R#1) never received her medications on the morning on 4/11/05. The facility administrator stated that she asked employee (E#7) "Did you give the medications today" and employee (E#7) told the administrator "No, I didn't give it".	A36	the MAR's, the physician orders and the Vital Signs to assure that staff remain in compliance with documented physician orders. 4. Completion Date 05/27/05	

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A36	Continued From page 19 F. On 4/19/05 During record review, it was noted that a physician's order was written on 2/8/05 that read: Resident (R#1) can take an additional Hyzaar 50/12.5 mg if BP>150/95. 1. Review of the medication record revealed that 11 out of 52 times, resident (R#1's) blood pressure was >150/95 and no Hyzaar was administered. G. On 4/19/05 During record review, it was noted that a physician's order was written on 2/11/05 for "Daily Blood Pressure Checks". 1. Review of the facillity's medication record revealed that 21 of 52 opportunities were not documented as having a blood pressure checked. Record review also revealed that the last blood pressure that was checked was on 4/7/05. No Blood Pressure checks were done from 4/1/05 to 4/6/05 or 4/8/05 to 4/10/05 and resident (R#1) was found deceased on 4/11/05. H. On 4/19/05 at 9:50A.M. During interview with the facility administrator, she stated that she was under the impression that staff was writing resident (R#1's) vitals, and BP's in the med sheet but staff was not. The facility administrator also stated that "if it's not there, then it's not going to be there". "There is no where else it would be documented". The facility administrator also stated that "she did not see the physician's order dated 2/11/05 for daily blood pressure checks to be done".	A36		