STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROV DER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2182	A. BUILDING: _____ B. WING _____	R 01/13/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASA MIS ABUELOS, LLC	4916 LARCHMONT DRIVE NE ALBUQUERQUE, NM 87111

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{A 000}	Initial Comments An revisit survey for survey dated 07/22/15 was completed on 1/19/16 for the state requirements of 7 NMAC 8.2, Regulations for Assisted Living. Deficiencies were cited as result of the survey. Repeat Deficiencies were cited as result of the survey.	{A 000}		
{A 035}	7 NMAC 8.2.35 Medication MEDICATIONS: Administration of medications or staff assistance with self-administration of medications shall be in accordance with state and federal laws. No medications, including over-the-counter medications, PRN (when needed) medications, or treatment shall be started, changed or discontinued by the facility without an order from the physician, physician assistant or nurse practitioner and with entry into the resident's record. A. State board of nursing licensed or certified health care professionals are responsible for the administration of medications. Administration may only be performed by these individuals. B. Facility staff may assist a resident with the self-administration of medications if written consent by the resident is given to the administrator of the facility or the administrator ' s designee. If the resident is incapable of giving consent, the surrogate decision maker named in accordance with New Mexico law may give written consent for assistance with self-administration of medications. All staff that assist with self-administration of medications shall have successfully completed a state approved assistance with self-administration of medication training program or be licensed or certified by the state board of nursing. C. PRN (pro re nada) medication.	{A 035}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROV DER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2182	A. BUILDING: _____ B. WING _____	R 01/13/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASA MIS ABUELOS, LLC	4916 LARCHMONT DRIVE NE ALBUQUERQUE, NM 87111

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{A 035}	Continued From page 1 (1) Physician or physician extender ' s orders for PRN medications shall clearly indicate the circumstances in which they are to be used, the number of doses that may be given in a 24-hour period and indicate under what circumstances the primary care practitioner (PCP) is to be notified. (2) The utilization of PRN medications shall be reviewed routinely. Frequent or escalating use of PRN medications shall be reported to the PCP. D. Only a licensed nurse (RN or LPN) shall administer any medications or conduct any invasive procedures provided by the following routes: intravenous (IV), subcutaneous (SQ), intramuscular (IM), vaginal or rectal. Only a licensed nurse shall administer non-premixed nebulizer treatments. E. The facility shall have medication reference material that contains information relating to drug interactions and side effects on the premises. Staff that assist in the self-administration of medications shall know interactions or possible side effects that might occur. F. Medications prescribed for one resident shall not be used for another resident. G. Medication assistance record (MAR). For residents who are not independent and require assistance with self administration, the facility shall have a MAR that documents the details of the residents' medication, including PRN and over-the-counter medication that is assisted with self-administration by qualified staff or administered to the resident by licensed or certified staff. The information in the MAR shall include: (1) the resident's name; (2) any known allergies to medication that the resident has; (3) the name of the resident's PCP or the prescriber of the medication;	{A 035}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROV DER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2182	A. BUILDING: _____ B. WING _____	R 01/13/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASA MIS ABUELOS, LLC	4916 LARCHMONT DRIVE NE ALBUQUERQUE, NM 87111

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{A 035}	Continued From page 2 (4) the diagnosis or reason for the medication; (5) the name of the medication, including the drug product brand name and the generic name; (6) notation if the medication is a schedule II-IV drug; (7) the dosage of the medication; (8) the strength of the medication; (9) the frequency or how often the medication is to be taken or given; (10) the route of delivery for the medication (mouth, eye, ear, other); (11) the method of delivery for the medication (pills, drops, IM injection, other); (12) the date that the medication was started or discontinued; (13) any change in the medication order; (14) pre-medication information (i.e., pulse, respiration, blood pressure, blood sugar) as required by the medication order; (15) the date and time that the medication is self-administered, administered with assistance or is administered; (16) the initials and signature of the person assisting with or administering the medication; (17) the desired results obtained from or problems encountered with the medication (pain relieved, allergic reaction, etc.); (18) any refused dose of medication; (19) any missed dose of medication; and (20) any medication error. H. No medication shall be stopped or started without specific orders from the primary care physician. I. If a resident refuses to take a prescribed medication, it shall be documented and the facility shall report it to the prescriber. J. A suspected adverse reaction to a medication shall be documented on the MAR and reported immediately to the PCP and the resident's	{A 035}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROV DER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2182	A. BUILDING: _____ B. WING _____	R 01/13/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASA MIS ABUELOS, LLC	4916 LARCHMONT DRIVE NE ALBUQUERQUE, NM 87111

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{A 035}	Continued From page 3 surrogate decision maker. If applicable, emergency medical treatment shall be arranged. Documentation of the event shall be kept in the resident's record. K. Prescription medication, other than blister packs and unit dose containers, shall be kept in the original container with a pharmacy label that includes the following: (1) the resident's name; (2) the name of the medication; (3) the date that the prescription was issued; (4) the prescribed dosage and the instructions for administration of the medication; and (5) the name and title of the prescriber. L. Any medication that is removed from the pharmacy container or blister pack shall be given immediately and documented by the staff that assisted with the medication delivery. M. The facility shall report all medication errors to the physician, documentation of medication errors and the prescriber's response shall be kept in the resident's record. N. The facility shall develop and follow a written policy for unused, outdated, or recalled medications kept in the facility in accordance with 16.19.11.10 NMAC (AS AMENDED). [7.8.2.35 NMAC - Rp, 7.8.2.35 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.35 G (2) (4) (5) (16) (17) (18) (19) Based on record review and interview the facility failed to ensure that the Medication Administration Record (MAR) for 3 residents (R #s 4, 5 and 6) of 3 (R #s 4, 5 and 6) residents	{A 035}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROV DER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2182	A. BUILDING: _____ B. WING _____	R 01/13/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASA MIS ABUELOS, LLC	4916 LARCHMONT DRIVE NE ALBUQUERQUE, NM 87111

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{A 035}	Continued From page 4 reviewed for medication accuracy were complete, accurate and included the following documentation: 1. The name of the residents Primary Care Physician (PCP). 2. The diagnosis or reason for the medication. 3. The name of the medication including the drug product brand name and the generic name. 4. The identifying initials and signatures of the caregivers (CG) assisting the residents with their medications. 5: That caregivers initial the MAR when they assist a resident with their medications and document any missed medications and the reason why. If the information on the MAR is not complete, accurate, and includes all required information then medication errors could occur and result in residents being harmed or require medical treatment. The findings are: Findings related to physician name documentation A. Record review of the January 2016 MAR's for R #4 and #6 revealed no documentation of the physician's name. B. On 01/08/16 at 3:59 pm, during interview with Administrator, he confirmed there is no documentation of the physician's name on the [redacted] 2016 MAR's for R #4 and #6. Findings related to the diagnosis or reason for the medication C. Record review of the [redacted] 2016 MAR's for R #6 revealed "no diagnosis or reason for" the following prescribed medications: [redacted]	{A 035}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROV DER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2182	A. BUILDING: _____ B. WING _____	R 01/13/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASA MIS ABUELOS, LLC	4916 LARCHMONT DRIVE NE ALBUQUERQUE, NM 87111

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{A 035}	Continued From page 5 [redacted]	{A 035}		

D. On 01/08/16 at 3:59 pm, during interview with Administrator, he confirmed there were no diagnosis or reason for R #6's prescribed medications documented on the January 2016 MAR.
Finding related to brand/generic names of medication documentation.
E. Record review of the January 2016 MARs revealed no documentation of both the brand and generic names of any of R #s 4, 5, and 6's medications.

F. On 01/19/15 at 10:00 am, during interview with the Administrator and the House Manager, they confirmed there was no documentation of both the brand and generic names of the medications listed the January 2016 MAR's for R #s 4, 5 and 6.

Findings related to the initials and signatures of staff who assist/administer medications.

G. Record review of the January 2016 MAR for R # 4 revealed no documentation of the initials and signatures (electronic) of the House Manager or caregivers (CG #1, 3, 4, 6, 7) who had assisted the resident with [redacted] medications.

H. Record review of the [redacted] 2016 MAR for R #5 revealed that CG #2 and #6 signed the MAR, that they assisted the resident with [redacted] medications, however, there is no documentation of the names of CG #2 and #6 on the electronic MAR.

I. Record review of the January 2016 MAR for R

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROV DER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2182	A. BUILDING: _____ B. WING _____	R 01/13/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASA MIS ABUELOS, LLC	4916 LARCHMONT DRIVE NE ALBUQUERQUE, NM 87111

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{A 035}	Continued From page 6 #6 revealed revealed no documentation of the initials and signatures (electronic) of the House Manager or caregivers (CG #1, 3, 6) who signed as having assisted the resident with [redacted] medications. J. On 01/19/15 at 10:00 am, during interview with Administrator and House Manager, they confirmed there was no documentation of the initials and signatures for the above listed caregivers on the January 2016 MAR's who signed as assisting R #s 4, 5, and 6 with their medications. Finding regarding caregivers not signing the MAR when assisting residents with medications K. Record review of the [redacted] 2015 MAR for R #4 revealed that on [redacted]/15 there is no documentation by a caregiver that R #4 received the following 8:00 am medication doses:  L. Record review of the facility "Medication Is Out or Not Given" form for R #4 revealed no documentation to indicate if or why the resident missed the above listed medications. M. Record review of the [redacted] 2015 MAR for R #4 revealed that there is no documentation on [redacted]/15 by the caregiver that R #4 received	{A 035}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROV DER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2182	A. BUILDING: _____ B. WING _____	R 01/13/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASA MIS ABUELOS, LLC	4916 LARCHMONT DRIVE NE ALBUQUERQUE, NM 87111

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{A 035}	Continued From page 7 the following medications: [redacted] N. Record review of the facility "Medication Is Out or Not Given" form for R #4 revealed no documentation as to if or why [redacted] did not received the medications. O. Record review of the [redacted] 2016 MAR for R #6 revealed that on [redacted]/16 there is no documentation by a caregiver that R #6 received [redacted] P. Record review of the [redacted] 2016 MAR for R #6 revealed that on [redacted]/16 and [redacted]/16 there is no documentation by a caregiver that R #6 received the following medications: [redacted]	{A 035}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROV DER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2182	A. BUILDING: _____ B. WING _____	R 01/13/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASA MIS ABUELOS, LLC	4916 LARCHMONT DRIVE NE ALBUQUERQUE, NM 87111

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{A 035}	Continued From page 8 [redacted] Q. Record review of the [redacted] 2016 MAR for R #6 revealed that on [redacted]/16 there was no documentation by a caregiver that R #6 received [redacted] R. Record review of the January 2016 MAR for R #6 revealed that there was not a "Medication Is Out or Not Given" form available for review, therefore there was no documentation indicating whether or not R #6 received the above listed medications in January 2016. S. On 01/19/15 at 10:00 am, during interview with Administrator and House Manager, they confirmed that the December 2015 MAR for R #4 and the January 2016 MAR for R #6 had blank spaces where the caregivers should have initialed if the resident received the medications or initialed-circled spaces indicating the resident did not receive the medications including documentation on the Medication Not Given or Out form the reason why the resident did not receive the medication. The Administrator and House Manager also confirmed that there was no documentation on R #4's Medication Not Given or Out form for the days on her December 2015 MAR with blank or initial-circled spaces and that there was no Medication Not Given or Out form available for review for R #6's January 2016 MAR. Neither the Administrator or House Manager could confirm whether or not R #4 and #6 received their medications on the days with blank spaces on the MARs.	{A 035}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROV DER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2182	A. BUILDING: _____ B. WING _____	R 01/13/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASA MIS ABUELOS, LLC	**4916 LARCHMONT DRIVE NE ALBUQUERQUE, NM 87111**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE