Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	5700	A. BUILDING _____ B. WING _____	10/01/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNRISE OF ALBUQUERQUE	4910 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
A22	7 NMAC 8.2.22 Resident Records	A22		

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

Scanned 10-19-09

RECEIVED OCT 2009 FACILITY LICENSING CERTIFICATION BUREAU

Division of Health Improvement

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Dan Sanders TITLE Executive Director (X6) DATE 10/12/09

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A22	Continued From page 1	A22		

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

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A22	Continued From page 2	A22		

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:
7.8.2.22(A)(3)(b) - Content of Resident Record

Based on record review and interview, the facility failed to ensure that the resident records contained all the required elements for 4 of 8 sampled residents (#1, #2, #3, #4,#5,#6,#,#7 and

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A22	Continued From page 3 #8). The findings are: A. On 09/28/09 at 11:00 AM during review of the resident's records, it was noted that the following documentation required within thirty (30) days of admission was missing from sampled residents files: - recent photograph (Resident #4) B. On 09/28/09 at 2:35 PM, during interview with the Wellness nurse, she acknowledged the stated document was not present in resident file.	A22	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. **A 22 7 NMAC 8.2.22 Resident Records** **1. Address how all violations identified in the official written record will be corrected.** The photo of resident #4 was taken and placed in the files.	
A26	7 NMAC 8.2.26 Resident Assessment 7.8.2.26 RESIDENT ASSESSMENT: A. A resident assessment to determine level of function and if the client's needs can be met by the facility. The initial assessment must be completed within five (5) days of admission and reviewed every six (6) months as part of the individual service plan. B. The resident assessment must establish a baseline in the resident's functional status and thereafter, identify resident changes through periodic reassessments. C. The resident assessment must be documented on a state approved resident assessment form and at a minimum include the following: (1) Cognitive patterns. (2) Communication/hearing patterns. (3) Vision patterns. (4) Physical functioning and structural problems. (5) Continence. (6) Psycho social well-being.	A26	**2. How the facility will identify other residents having the potential to be affected by the same deficient pratice.** All residents have the potential failure to have their photos not taken and entered in their files. **3. how the facility will monitor its corrective action.** The ALC, HCC, or WN shall check each file when the required assessments and ISP is updated to insure that an updated photo is taken and entered uinto the files. **4. Specify a date when the corrected action will be completed.** The photo was taken and placed in thwe files on 10/7/09.	10/7/09

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A26	Continued From page 4 (7) Mood and behavior patterns. (8) Activity pursuit patterns. (9) Disease diagnoses. (10) Health conditions. (11) Oral/nutritional status. (12) Oral/dental status. (13) Skin conditions. (14) Medication use. (15) Special treatment and procedures. D. The resident admission assessment, the physical exam report, and the observation and evaluation of staff with regards to the needs will be used to develop the individual service plan, if needed. If the resident assessment does not indicate a need for an individual service plan, then an individual service plan is not required. However, an individual service plan must be prepared for residents requiring nursing services. [4-7-97; 7.8.2.26 NMAC - Rn, 7 NMAC 8.2.26, 8-31-00] This REQUIREMENT is not met as evidenced by: 7.8.2.26 - Resident Assessment Based on record review and interview, the facility failed to ensure that resident assessments were completed every six months as required for 1 of 8 sampled residents (Resident's #6). The findings are: A. On 09/28/0909 at 1:00 PM during review of resident records, it was noted that current resident assessments were not complete for all residents. Resident #6's most current assessment on file was dated 09/30/08. B. On 09/28/09 at 2:00 PM during an interview with Wellness nurse, she acknowledged the finding.	A26	**A26 7 NMAC 8.2.26 Resident Assessment** **1. Address how all violations identified in the official written report will be corrected.** The resident assessment for resident #6 was misfiled. The date of the assessment is 3/26/09 and was placed in the resident file. A new updated assessmernt dated 9/22/009 was completed and also placed in the file. **2. How the facility will identify other residents having the potential to be affected by the same deficient practice.** All residents have the potential of not having an assessment completed timely and/or misfiled. The ALC, HCC, or WN shall check each file when the required assessments are due to insure that the assessment isfiled correctly and/or is complete as required. **3. How the facility will monitor its corrective action.** The Merlin tool is monitored at the bi-weekly Merlin meeting by the ED, ALC, RC, HCC, BOC, and WN to insure that required assessments are completed in a timely manner. **4. Specify a date upon which the corrective action will be completed.** The assessment was completed timely and the misfiled assessment placed correctly in the resident file.	10/7/09

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A27	7 NMAC 8.2.27 Individual Services Plan	A27		

7.8.2.27 INDIVIDUAL SERVICE PLAN:

A. An individual service plan, if prompted by the resident assessment, shall be developed and implemented within fourteen (14) days of admission, and must address those areas of need as identified in the resident assessment. The individual service plan must be reviewed by a licensed nurse at least every six (6) months, and revised as needed at the time of each assessment and consistently implemented in response to the resident's needs.

B. The individual service plan must include the following:

(1) Description of identified needs as noted in the resident assessment.

(2) Written description of what services will be provided.

(3) Who will provide the services.

(4) When or how often the services will be provided.

(5) How the services will be provided.

(6) Where the services will be provided.

(7) Goal and outcome of the service.

(8) Documentation of the facility's determination that it is able to meet the needs of the resident..

[7-11-86, 1-11-90, 4-7-97; 7.8.2.27 NMAC - Rn, 7 NMAC.8.2.27, 8-31-00]

This REQUIREMENT is not met as evidenced by:

Refer to 7.8.2.27 A..

Based on records review and interview, the facility failed to ensure that the individual service plans, were reviewed by a licensed nurse at least every six months and revised as needed for 1 of 8 sampled residents.

The findings are:

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A27	Continued From page 6	A27		

A. On 09/28/09 at 1:00 PM during review of resident records, it was noted that current resident care plans were not complete for all residents. Resident #7's most current care plan on file, that had been reviewed by a nurse, was dated 12/28//08. .

B. On 09/28/09 at 2:00 PM during an interview with the Wellness nurse, she acknowledged the finding.

A27 7 NMAC 8.2 26 Individual Service Plan

1. Address how all violations identified in the official written report will be corrected.
The resident Individual Service Plan for resident #7 was misfiled. The date of the ISP is 6/27/09 and has been placed in the resident file.

2. How the facility will identify other residents having the potential to be affected by the same deficient practice.
All residents have the potential of not having an Individual Service Plasn completed timely, and/or misfiled. The ALC,HCC, or WN shall check each file when the required assessments are due to insure that the ISP is complete as required and filed correctly.

3. How the facility will monitor its corrective action.
The Merlin tool is monitored at the bi-weekly Merlin meeting by the ED, ALC, RC, HCC, and WN to insure that required assessmentsare completed in a timely manner. The ISP is completed after the assessment is completed.

4. Specify a date upon which the corrective action will be completed.
The ISP was completed timely and the misfiled assessment placed correctly in the resident file on 10/06/09.

10/6/09