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2nd Original	5399	A. BUILDING _____ B. WING _____	C 11/24/2009

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SENIOR LIVING SYSTEMS HWY 47	3216 HIGHWAY 47 S LOS LUNAS, NM 87031

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A 01	OPENING REMARKS Surveyor: 22697 A Complaint Investigation was completed on 11/24/09. Complaint Investigation Intake number NM00027370. Source reported resident neglect. Complaint was unsubstantiated, but deficiencies were cited.	A 01	Signed 1/8/10	
A36	7 NMAC 8.2.36 Medications 7.8.2.36 MEDICATIONS: Medications will be administered or staff assistance with medications provided and documented in accordance with state and federal laws. A. Licensed health care professionals are responsible for the administration of medications. B. Facility staff may assist a resident with medications if written consent by the resident is given to the director of the facility or their designee. If the resident is incapable of giving consent, the resident's guardian, treatment guardian or surrogate decision maker named in accordance with New Mexico law may give written consent for the assistance with medications. All staff assisting with medications shall have successfully completed an approved assistance with medication training program or be licensed by the State of New Mexico to administer medications. C. No medications, including over the counter medications, PRN (when needed) medications, or treatment shall be started, changed or discontinued by the facility without an order by the physician and entry into the resident's record. D. The facility must have on the premises, medication reference material that contains information relating to drug interactions and	A36	RECEIVED JAN 2010 HEALTH FACILITY LICENSING & CERTIFICATION BUREAU	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE 1/4/10 Director (X6) DATE

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A36	Continued From page 1	A36		

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 use of the medication.
(b) Exact dosage to be used.
(c) The exact amount of medication to

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A36	Continued From page 2 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: 22697 Refer to 7.8.2.36 A. Licensed health care professionals are responsible for the administration of medications. Based on record review and interview the facility failed to have licensed health care professionals administering medications to a resident who is mentally incapable of self administering medications. (R1) This deficient practice has the potential to affect all (100%) of residents admitted to the facility who are incapable of self administration of medications. The findings are: Record review on 11/16/09 of complaint number NM00027370 received on 11/13/09 revealed the source of the complaint reported the following: ". . . patient [resident R1] baseline is higher functioning prior to incident. According to H&P, [History and Physical] "Hx [History] is limited secondary to patient being unresponsive. To chart review and speaking with the ER	A36		

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A36	Continued From page 3 [Emergency Room] doctor, patient [resident R1] was inadvertently giving [sic] another patient's medications to include Clozapine. EMS was called and patient was responsive upon arrival; en route [sic] and in ER, he became unresponsive. He was intubated and transferred to ICU." Record review on 11/17/09 of hospital records dated 11/9/09 for resident R1 revealed the following: "Page 1 of 3 . . . Age: 69 [elderly] . . . Admission date: 11/08/2009 21:31 [9:31 p m] . . . REASON FOR ADMISSION: 1. Coma. 2. Unintentional overdose with clozapine. 3. Respiratory failure. 4. History of Korsakoff encephalopathy. 5. History of alcoholism. HISTORY OF PRESENT ILLNESS: History is limited secondary to patient being unresponsive to chart review and speaking with the emergency room physician. Briefly, patient was inadvertently given another patient's medication at the nursing home assisted living center to include clozapine. EMS [Emergency Medical Services] was called and patient was responsive upon arrival; however, en route and once in the emergency room he became unresponsive. He was intubated and transferred to the ICU." "Page 2 of 3 . . . REVIEW OF SYSTEMS: Unobtainable as patient is in a coma, intubated on mechanical ventilation. . . . ASSESSMENT AND PLAN: . . .	A36		

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A36	Continued From page 4 1. Coma. Patient will be provided with supportive care. He is full code and at this time, suffering from the effects of an inadvertent clozapine overdose. . . . " Record review on 11/1809 of the Drug Information Handbook for Nursing revealed the following for Clozapine: "Restrictions: Patient-specific registration is required to dispense clozapine. . . . Pharmacologic Category: Antipsychotic Agent, Atypical. . . . Contraindications; Hypersensitivity to clozapine or any component of the formulation; . . . severe central nervous system depression or comatose state . . . Warnings/Precautions: Patients with dementia-related behavioral disorders [i. e. Korsakoff encephalopathy] treated with atypical antipsychotics are at an increased risk of death compared to placebo. Clozapine is not approved for this indication. . . . Dosing: . . . Elderly: Oral: . . . initial dose should be 25 mg/day: increase as tolerated by 25mg/day to desired response. Maximum daily dose in the elderly should probably be 450 mg. Dose titration to 300-450 mg/day may be attained in 2 weeks if tolerated; however, elderly may require slower titration and daily increases may not be tolerated. Review of records for resident R1 on 11/17/09 revealed resident R1 does not have Physician's orders for Clozapine or any other antipsychotic medication.	A36		

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A36	Continued From page 5 Review of records for resident R2 on 11/17/09 revealed resident R2 is not elderly and there are Physicians orders for resident R2 to be administered a total of 850 mg of Clozapine at bedtime daily. In an interview with staff S16 on 11/17/09 at 2:06 p m, staff S16 acknowledged preparing resident R2's medications in a cup which included the dose of clozapine. Staff S16 stated, "I pop the pills into a cup for [resident R2], was distracted, and took them to [resident R1]. This surveyor asked, "Where was he [resident R1]?" Staff S16 answered, "He [resident R1] was in his bedroom. When I came back I realized and called poison control." This surveyor asked staff S16 if she knew any details about Clozapine. Staff S16 only said it was for Schizophrenia. Staff S16 was asked if there was Drug reference materials available at the facility. Staff S16 acknowledged she did not know of any drug reference materials at the facility and stated, "Only what is on the MAR [Medication Administration Record]." Staff S16 further acknowledged not being a licensed medical professional. Review of the Medication Administration Record (MAR) for resident R2 on 11/17/09 revealed no drug information about Clozapine and only had the Physicians orders for dosage instructions written on the MAR. In an interview with resident R1 on 11/17/09 at 11:13 a m, this surveyor asked resident R1 the following questions and resident R1 gave the following responses: Surveyor: "When your medications are brought to you, do you know what you are taking?" R1: "Not half the time." Surveyor: "If I brought your medications in here, could you tell me what you	A36		

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A36	Continued From page 6 are taking each one for?" R1: "No." Surveyor: "Do you remember being in the hospital?" R1: "I know I was there, but not how long [pause] about 12 days." Surveyor: "Do you know why you were there?" R1: "No I don't [pause] blacked out somewhere." Review of records for staff S16 on 11/17/00 revealed no professional medical license. In a telephone interview with staff S17 on 11/24/09 at 2:50 p m, staff S17 acknowledged the facility does not have any licensed medical professionals on staff at the facility. Record review on 11/16/09 of the hospital discharge instructions for resident R1 dated 11/13/09 the following was noted: "Recommended Disposition: SNF [Skilled Nursing Facility]" Summation: 1. Resident R1 was given an overdose of Clozapine, an Antipsychotic. 2. The Clozapine was not prescribed for resident R1. 3. Due to Diagnosis of Korsakoff encephalopathy, resident R1 is not capable of self administration of medications and did not realize he took different pills. 4. The Caregiver that administered the medications is not a licensed medical professional. 5. The facility does not employee any licensed medical professionals for the administration of medications. 6. The hospital discharge plan specified resident R1 should be admitted to a Skilled Nursing facility. 7. The facility is not a Skilled Nursing Facility and	A36		

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A36	Continued From page 7 admitted resident R1 back into the facility. 8. The hospital discharge plan was in possession of the facility.	A36	1. Facility has written consent from POA to assist with medications Retention/Exception plan on file at facility with Total Community Care. Family and physician in agreement with the return of resident to AL 2. Discharge paperwork from Presbyterian indicated that return to AL appropriate level of care (dated 11/13/2009) 3. Staff receive additional training on drug side effects and use of drug reference materials 4. Completed by 1/10/2010 Residents with memory difficulties and diagnosis may have assistance with medications if the family or resident gives consent for the delegation of assistance as otained through our admission agreement	