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 _____	10/17/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNRISE OF ALBUQUERQUE	4910 TRAMWAY RIDGE DRIVE NE ALBUQUERQUE, NM 87111

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A19	7 NMAC 8.2.19 ADMISSIONS 7.8.2.19 ADMISSIONS: No resident shall be admitted or retained who is below the age of eighteen (18) or for whom the facility is unable to provide appropriate care. EXCEPTION: Maternity Shelters may accept residents below the age of eighteen (18). A. ADMISSION INTERVIEW. The Director of the facility or a designee responsible for admission and retention decisions, shall meet with the resident or the resident's agent or guardian, if the resident lacks decision-making capacity, and shall provide the resident with: (1) The facility's program narrative. (2) The facility's rules. (3) The facility's admission agreement, including costs and charges, refund provision, and contract termination policies. (4) The facility's bed hold policy. (5) Information about the resident's right under New Mexico Law to make decisions regarding health care, including the right to make advance directives. (6) A written description of the legal rights of the residents translated into another language, if necessary. (7) The facility's staffing pattern. B. RESTRICTIONS ON ADMISSIONS: Adult residential care facilities shall not admit or retain individuals requiring continuous nursing care. Conditions or circumstances that usually require continuous nursing care, may include, but not limited to the following: (1) Ventilator dependency. (2) Pressure sores where skin loss penetrates beyond the skin, and into deeper tissue or bone, which are classified as Stage III or IV. (3) Intravenous therapy or injections directly into the vein.	A19	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. A19 NMAC 8.2.19 ADMISSIONS 1. With respect to the specific item cited: The Individual Service Plan (ISP) team met on 6/29/07 to review the care plan. The updated plan was mailed to Licensing & Certification Bureau on 10/30/07. 2. With respect to how the community will identify residents with the potential to be affected by the identified concern: In the future, any resident who is referred to Hospice or third party provider, the ISP will be sent to L&C after the team meeting. 3. With respect with what systematic measures have been put into place to address the stated concern: The ED, ALC, and/or HCC will perform chart reviews on residents requiring third party services on a quarterly basis. 4. With respect to specifying a date which the corrective action will be completed. The ISP took place on 6/29/07. The ISP was sent to L&C on 10/30/07.	10/30/07

ED Scanned 11-13-07

Division of Health Improvement

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Executive Director — (X6) DATE: 11-1-07

STATE FORM 6899 6HHS11 — If continuation sheet 1 of 9

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A19	Continued From page 1 (4) Airborne infectious disease, in a communicable state, including tuberculosis, but excluding infections such as the common cold. (5) Any condition requiring either physical or chemical restraints. (6) Nasogastric tubes / gastric tubes. (7) Tracheostomy care. (8) Individuals presenting an imminent physical threat or danger to self or others. (9) Individuals whose physician certifies that placement is no longer appropriate. C. ADMISSION/RETENTION EXCEPTIONS: If a resident requires a greater degree of care than the facility would normally provide, or is permitted to provide, and the resident wishes to be re-admitted or to remain in the facility, and the facility wishes to re-admit or retain the resident, the facility must: (1) Convene a team, comprised of: (a) The facility director. (b) The resident. (c) The resident's agent, guardian or surrogate decision maker. (d) The resident's advocate, such as the resident's case manager, Ombudsman, or social worker. (e) If the treating physician is unable to meet with the team, then consultation and recommendations via phone is acceptable. (f) Other appropriate health care professionals. (2) The team shall jointly determine if the resident should be admitted or allowed to remain in the facility. The team must approve a individual service plan that meets the specific needs of the resident. Such team approval must be in writing, signed and dated by all team members, must be maintained in the resident's record, and must: (a) Be based upon a individual service plan which identifies the resident's specific needs	A19		

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A19	Continued From page 2 and addresses the manner that such needs will be met. (b) Ensure that the facility has and will maintain an evacuation rating of prompt or slow as determined by the Fire Safety Equivalency System (FSES). (c) Be based upon an assessment of the health, safety and well-being of the other facility residents. (d) Assess the impact that meeting the specific needs of the resident as set out in the individual service plan will have on the staff and on the other residents. (3) Notify the Licensing Authority within five (5) days of the completion of team approval. Such notification of team approval must be submitted in writing and include evidence of the team's consideration of items 7.8.2.19C2(a) through 7.8.2.19C2(d) above. [9-24-76, 7-11-86, 1-11-90, 4-7-97;7.8.2.19 NMAC - Rn. 7 NMAC 8.2.19, 8-31-00] This REQUIREMENT is not met as evidenced by: Refer to 7.8.2.19(C)(3) Based on record review and interview, the facility failed to notify licensing authority within five (5) days of the completion of the team approval meeting for 1 of 1 resident who requires nursing services. The findings are: A. Review of the resident record on 10/15/07,revealed there was no documentation that licensing authority had been notified within the five (5) days of the team approval meeting for 1 of 1 resident who is currently receiving the services of a hospice nursing agency since	A19		

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A19	Continued From page 3 06/29/07. B. During an interview with the assisted living coordinator On 10/15/07 at 3:45 PM, she acknowledged that licensing had not been notified.	A19		
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. (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.	A26	A26 7 NMAC 8.2.26 RESIDENT ASSESSMENT 1. With respect to the specific item cited: Sunrise Senior Living policy and procedure requires that residents will be assessed by the Health Care Coordinator and the Assisted Living Coordinator at move-in, and every six months thereafter or sooner, if there is a change in the resident's condition. During the past year, we hired and lost three HCC's, causing us to get behind in assessments. We are now in the process of reviewing and updating assessments by the HCC and the ALC. 2. With respect to how the community will identify other residents with the potential to be affected by the identified concern: All assessments will be reviewed and updated by the HCC and ALC within the next three months and will track with the new ISP's, which have a built-in tickler system which requires a new ISP every six months. 3. With respect to what systematic measures have been put into place to address the stated concern: The ED, HCC, and/or the ALC will audit Wellness Charts on a quarterly basis to insure compliance. 4. With respect to specifying a date when the corrective action will be completed: All assessments will be brought up to date within three months. They should then be on the six month tracking system.	11/20/07

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A26	Continued From page 4 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: Refer to 7.8.2. 26 (A) Based on record review and interview, the facility failed to ensure the resident assessments were reviewed every six months for 10 of 10 residents. The findings are: A. Review of resident records on 10/16/07, revealed that the resident assessments were not reviewed every six months for 10 of 10 residents. B. During an interview with the health care coordinator on 10/16/07 at 10:00 am she acknowledged the problem.	A26		
A27	7 NMAC 8.2.27 INDIVIDUAL SERVICE PLAN 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	A27		

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A27	Continued From page 5 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 record review and interview, the facility failed to ensure the individual service plans were reviewed every six months for 10 of 10 residents. The findings are: A. Review of resident records on 10/16/07, revealed that the individual service plans were not reviewed every six months for 10 of 10 residents. B. In an interview with the health care coordinator on 10/16/07 at 10:00 am, she acknowledged the problem.	A27	A27 NMAC 8.2.27 INDIVIDUAL SERVICE PLAN 1. With respect to the specific item cited: Approximately three months ago, Sunrise Senior Living changed the format of the ISP for residents. Since that time, we have been updating ISP's to the new format. This was recently completed; however, not within the six month period of the previous ISP. Copies of the ISP's are entered into the Resident Services Book, which are accessible to the care managers. The original copy is to be filed in the Wellness chart. Copies are being made and filed appropriately. The ISP's are now on track due to the format of the new ISP's. 2. With respect to how the community will identify residents with the potential to be affected by the identified concern: Coordinators have been in-serviced on the policy & procedure of updating ISP's. The new ISP's have a built-in tickler system which requires a new ISP every six months. 3. With respect to what systemic measures have been put in place to address the stated concern: The ED, HCC, and/or ALC will audit Wellness charts on a quarterly basis to insure compliance. 4. With respect to specifying a date when the corrective action will be completed: All ISP's have now been updated. Within three months, ISP's should all be filed appropriately and be on the six month schedule track.	11/30/07
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,	A35		

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A35	Continued From page 6	A35		

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 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

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A35	Continued From page 7 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 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: 7.8.2.35 (B) (1) Based on record review and interview, the facility failed to ensure that the quarterly consultant pharmacist reviews were conducted.	A35		

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A35	Continued From page 8 The findings are: A. Review of facility records on 10/16/07, revealed that the quarterly consultant pharmacist reviews were not done for March 2006; June 2006; September 2006; and March 2007. B. In a interview with the healthcare coordinator on 10/16/07 at 10:45 am, she acknowledged that the quarterly reviews were not done for March,June and September of 2006 and for March of 2007.	A35	A35 NMAC 8.2.35 CUSTODIAL DRUG PERMIT 1. With respect with the specific item cited: Facility quarterly pharmacy reviews were done in 2006 and 2007. Unfortunately, the previous HCC did not file reviews in an orderly manner. We have reviews for 2/06, 5/06, and 12/06, as well as for 7/07, and 10/07. We have contacted our consultant pharmacy for the missing copies. Nonetheless, the facility will now implement a procedure where the reports will be given and filed with both the HCC and the ED. These reports will be retired and retained as required by policy. 2. With respect to how the community will identify residents with the potential to be affected by the identified concern: The HCC and the ED will keep a tickler file on when reviews are due so that the consultant pharmacist will be called and reminded if he has not already scheduled a review. 3. With respect with what systemic measures have been put in place to address the stated concern: The HCC and the ED will both be responsible to insure that reviews are done timely, as required by regulation. 4. With respect to specifying a date when the corrective action will be completed: The ED will contact the consulting pharmacist to tentatively date the year's quarterly reviews so that both parties can plan accordingly.	11/30/07