Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2134	A. BUILDING _____ B. WING _____	10/15/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TWIN OAKS ASSISTED LIVING FACILITY	3051 TWIN OAKS DRIVE NW ALBUQUERQUE, NM 87120

(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
A 01	OPENING REMARKS Four (4) complaint investigations were completed on 10/15/2009 for NMAC 7.8.2-New Mexico Regulations Governing Adult Residential Care Facilities. 1. Intake # NM00027238 dated 8/20/2009 was SUBSTANTIATED with deficiencies cited. 2. Intake # NM00027282 dated 8/31/2009 was SUBSTANTIATED with deficiencies cited. 3. Intake # NM00027269 dated 8/26/2009 was UNSUBSTANTIATED. 4. Intake # NM00027314 dated 9/21/2009 was UNSUBSTANTIATED.	A 01	ES Scanned 12-11-09	
A13	7 NMAC 8.2.13 Grounds for Revocation or Suspension of Licen 7.8.2.13 GROUNDS FOR REVOCATION OR SUSPENSION OF LICENSE, DENIAL OF INITIAL OR RENEWAL APPLICATION FOR LICENSE, OR IMPOSITION OF INTERMEDIATE SANCTIONS OR CIVIL MONETARY PENALTIES: A. When the Licensing Authority determines that an application for renewal of a license is to be denied, or that a license is to be revoked, the Licensing Authority shall provide written notification to the adult residential care facility, the residents of the adult residential care facility and the surrogate decision maker for the resident. B. A license may be revoked or suspended, an initial or renewal application for license may be denied, or intermediate sanctions or civil monetary penalties may be imposed after notice and opportunity for a hearing, for any of the following reasons: 1. Failure to comply with any provision of these regulations. 2. Failure to allow a survey by	A13	RECEIVED DEC 2009 HEALTH FACILITY LICENSING & CERTIFICATION BUREAU	

Division of Health Improvement

Director — TITLE — 12/9/09 (X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

ORIGINAL

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A13	Continued From page 1 authorized representatives of the Licensing Authority. 3. Hiring or retaining any employee who has been convicted of a felony or misdemeanor related to abuse, neglect or exploitation, trafficking in controlled substances, criminal sexual penetration or related sexual offenses. 4. Misrepresentation or falsification of any information on application forms or other documents provided to the Licensing Authority. 5. Discovery of repeat violations of these regulations. 6. Failure to provide the required care and services as outlined by these regulations for the residents receiving care from the facility. 7. Exceeding licensed capacity. 8. Failure to provide an acceptable plan of correction. 9. Abuse, neglect or exploitation of any patient/client/resident by facility operator, staff or relatives of operator/staff. [7-1-64, 9-15-70, 5-26-72, 9-24-76, 7-11-86, 1-11-90, 4-7-97, 6-15-98; 7.8.2.13 NMAC - Rn, 7 NMAC 8.2.13, 8-31-00] This REQUIREMENT is not met as evidenced by: Refer to 7.8.2.13(B)(6) - Grounds for revocation or suspension of license, denial of renewal application for license, or imposition of intermediate sanctions or civil monetary penalties due to FAILURE TO PROVIDE CARE AND SERVICES as outlined by these regulations for the residents receiving care from the facility. Based on observation, record review, and interview, the facility failed to provide care and services to (1) resident of the facility (Resident	A13	7.8.2.13 B(6) 1-5 ① Facility will ensure that all residents currently needing Oxygen assistance equipment have on site operable and ample supplies of equipment, tanks and other supplies. Staff will complete In-Serv Training regarding * correct wearing/operation of O_2 systems * recognizing signs & symtoms of shortness of breath. * Monitoring of E-Tank and concentrators * Maint of O_2 equipment * Resident Service Plans * Actions to be taken in case of Emerg. * Reporting of Accidents/Incidents * First Aid Overview * Communication of residents needs Facility will implement new policy regarding monitoring of	

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A13	Continued From page 2 #1). The findings are: 1. On 8/31/09 during review of complaint intake report to the Department of Health revealed the following: Source states that complaint is regarding "abuse." Complainant source reports that Resident #1 could not breathe [sic] for on the previous Saturday at the facility due to lack of oxygen available at the facility for Resident #1. Review of Resident #1's file on 8/31/09 revealed that physician's orders on 1/29/08 included availability of an oxygen concentrator with E tanks as a back up source of oxygen for Resident #1. 2. On 8/31/09 from 4:30 PM to 4:50 PM during general facility observation Resident #1 was observed to be sitting upright in his motorized wheelchair and yelling "help me." Observation of Resident #1's green oxygen tank indicator yielded that the arrow was in "the red zone" and out of oxygen. There was no staff visible in the vicinity during this observation and this surveyor had to seek assistance for Resident #1 during this 20 minute span to make the facility aware of the issue and address the issue on behalf of Resident #1. 3. On 9/1/09 at 1:34 PM during interview, interviewee #12 reports that Resident #1 could not breathe due to failure of the oxygen concentrator for this resident over the course of the previous week as well as lack of tank oxygen at the facility during the previous weekend. Interviewee #12 stated that during this time, supervisory staff did not call 911 to assess Resident #1 even though he was experiencing breathing problems due to lack of oxygenation. However, interviewee #12 reports that during this time, Resident #1 made a phone call out of the facility. Interviewee #12 reports that neither	A13	1) Cont Residents to include: * O_2 stat readings for O_2 resident * every shift change and PRN * Weekly cleaning of O_2 equip. * Reporting of lack of and damaged equip to Mang, director, supplies and POAs. (2) Facility will review all Resident charts to ensure that Residents with O_2 needs have all required equipment and that equip is operable. (3) Director and/or Manager will on a daily basis ensure that staff members are monitoring Residents using Oxygen and their equip. to ensure that equipment is being used properly and that resident has all the required equip. Mang will review residents MAR and Incident Reports to ensure that staff is following policies + procedures.	

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A13	Continued From page 3 supervisory staff present at the time nor other staff present at the time called 911 for assistance to Resident #1. Interviewee #12 reports that eventually, Staff #1 was contacted regarding Resident #1. 4. On 9/1/09 at 2:00 PM, during general facility observation Resident #1 was observed to be sitting upright in his motorized wheelchair. Observation of Resident #1's oxygen tank indicator yielded that the arrow was in "the red zone." At 4:30 PM during observation Resident #1's tank green oxygen tank indicator yielded that the arrow was in "the red zone" and out of oxygen. 5. On 10/5/09 at 3:00 PM, during interview, Interviewee #7 indicated noticing Resident #1's oxygen not being on in times past as well as lack of availability of the green tank oxygen for this resident. Interviewee #7 reports receiving a phone call from Resident #1 in 8/09 and reports that during that conversation, Resident #1 asked for a visit from the Interviewee because of "problems with oxygen that had caused all (personnel) to be in the room (and) not knowing if [sic] would make it through the night." Interviewee #7 reports that the facility has a history of "horrible communication" regarding Resident #1 and was never contacted about lack of oxygen for Resident #1. Similarly, Interviewee #7 reports never having received information about failure of the oxygen concentrator, lack of oxygen availability from the facility on the weekend of 8/29/09 from the facility. Interviewee #7 reports that on 10/4/09 Interviewee #2 reported to Interviewee #7 that Resident #1 had been seen "gasping" for air recently.	A13	(4) 12/8/09 #First Inservice Training Completed 12/8/09	

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A13	Continued From page 4 7.8.2.13(B)(9) - Grounds for revocation or suspension of license, denial of renewal application for license, or imposition of intermediate sanctions or civil monetary penalties based on ABUSE OF RESIDENT BY STAFF of the facility. Based on record reviews and interviews, the facility failed to protect the residents of the facility from ABUSE by staff of the facility for one (1) facility resident (Resident #2). The findings are: 1. On 8/20/09 during general facility tour and afternoon observations, it was noted that Resident #2 was seen walking with a walker throughout the facility. Resident #2 greeted appropriately with a smile and was "dressed up" in bright colored clothing, wearing jewels, lipstick and a strikingly remarkable hat. Resident #2 commented appropriately on liking this surveyor's cowboy boots. 2. On 8/25/09 at 8:11 AM during interview, Interviewee #5 reports knowledge that Resident #2 had had a bladder infection and had an accident (bladder) on the facility floor as a result of that infection. Interviewee reports that supervisory staff had said that Resident #2 "was peeing all over the place." 3. On 8/31/09 during review of complaint intake report dated 8/13/09 to the Department of Health revealed the following: Source complaint indicates that supervisory staff are cursing in front of residents, families (of residents) and other (facility) workers. Review of complaint intake	A13	7.8.2.13 B(9) ① Staff will complete In-Serv. Training on 12/8-12/12/09 on regulations regarding Abuse and Neglect of residents. Staff will also complet In-Serv Training regarding: * Reporting of Incidents, Abuse + Neglect * Medication Assistance * Employee Conduct Notes (A) Interviewee #2 is no longer employed by facility due to inappropriate behaviors towards residents and staff members and not following company policies and procedures regarding resident care. (B) Resident #2 was asked to vacate facility due to inappropriate behaviors towards other residents and being verbally Abusive with other residents. This action	

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A13	Continued From page 5 report dated 8/26/09 to the Department of Health revealed the following: Source reports that supervisory staff is constantly "yelling" and that administration and other employees have been made aware of it. Similarly, on 8/31/09 during review of complaint intake report dated 8/31/09 to the Department of Health revealed the following: Source stated that complaint was regarding "abuse and neglect." Source reports knowledge that a resident of the facility has been verbally abused by supervisory staff and report that administration is aware that this is occurring. Specifically, it read that supervisory staff called a resident "stupid" and "bipolar." 4. On 9/1/09 at 12:59 PM, during interview, Interviewee #12 reports witnessing failure of Interviewee #6 to provide a medication to Resident #2. Interviewee #12 reported that Interviewee #2 gave Interviewee #6 a directive not to give Resident #2 the medication that the resident had requested. 5. On 9/1/09 between 6:19 - 6:59 PM, during observation, Resident #2 was seen wearing bright colored fashionable modern clothing, makeup and jewelry. On 9/1/09 between 6:19-6:59 PM during interview, Resident #2 reported the following: When she is walking with a walker around the facility, Resident reports seeing "everything." Discussion with Resident #2 included the following topics: Resident, family, facility, care and abuse/neglect. Regarding self and family, Resident #2 appropriately and accurately self reported being a "harmless eccentric" who has two children. Resident #2 reported being "closer" to a daughter but described great enjoyment derived when debating with a son over topics such as the Bible and politics. Resident #2 indicated awareness of	A13	(1 cont) was taken prior to survey. (2) Director will investigate and survey staff and residents to determine if there are any other related issues regarding resident care and treatment. (3) Director and/or Manager will on a weekly basis and by direct observation & verbal survey ensure that residents needs are being met and that staff are following policies and procedures regarding * Abuse and Neglect of Residents * Resident's Rights * Medication Assist. * Employee Conduct. (4) First Inservice Training Completed 12/8/09	

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A13	Continued From page 6 her medical conditions of diabetes and elevated blood pressure, and with a smile reports "loving to eat...gaining weight... and being a Christian." Regarding the facility, Resident #2 reported the following concerns: verbalizes that a medication assistant (Interviewee #6) almost gave her "too much insulin the other day" and that the facility administration had sent letters to the resident's family regarding notification to "move" the resident out of the building. Resident #2 reports requesting an "as needed" medication from a medication assistant over the past week (Interviewee #6) and being told that she could not have it because Interviewee #2 said "no." Resident #2 reported that because of "standing up" to supervisory staff (for personal needs) she suspected was the reason that the letter to vacate was sent. When asked directly about possible abuse, Resident #2 reported that Interviewee #2 had been directly verbally abusive. Specifically, Resident #2 reported having had a bladder infection at one time in the past and reports having lost control of urine on the floor. Resident #2 reported that Interviewee #2 would subsequently come into the room and ask "Did you pee on the floor?" and belittle her by reminding her that she had once had an bladder infection even though she currently did not have an infection and had already regained control of her bladder. Similarly, Resident #2 reported that Interviewee #2 was "nasty and hateful" and had also called her "'bipolar' even though I'm not." 6. On 9/1/09 at 5:47 PM, during review of Resident #2's chart, medical documents dated 6/5/08 indicated that Resident #2 did not have a diagnosis of bipolar disorder. Further documentation also indicated that Resident #2 had suffered an infection of the bladder in the past and had received medical treatment for the	A13		

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A13	Continued From page 7 infection. During the same time, a letter on facility letterhead dated 7/27/09 signed by Interviewee #1 was seen. The topic of this letter was "30 days notice" to vacate. 7. On 9/4/09 at 11:40 AM, during interview, Interviewee #10 reported having been called an "idiot" by Interviewee #2. Interviewee #10 reported that at the facility all resident needs were secondary to "cleaning" duties and specifically mentioned Resident #2's needs were not met because supervisory staff was "rude... and doesn't want for [staff] to help" Resident #2 "put on her pants." 8. On 8/21/09 at 3:45 PM, during interview, Interviewee #1 reported witnessing supervisory staff yelling (at other staff) in front of facility residents. 9. On 9/1/09 at 3:00 PM, during interview, Interviewee #15 reported knowledge that supervisory staff yells (at staff). 10. On 10/7/09 at 3:10 PM, during interview, Interviewee #8 stated that "everyone in the facility (except for administrative staff) reports to" Interviewee #2. Interviewee #8 further stated that Interviewee #2 was the person in charge of ordering pills and the person to speak to regarding resident issues.	A13		

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A13	Continued From page 8 7.8.2.13(B)(9) - Grounds for revocation or suspension of license, denial of renewal application for license, or imposition of intermediate ~~sanctions~~ or civil monetary penalties based on NEGLECT OF RESIDENT BY STAFF of the ~~facility~~. Based on observation, record review and interview, the facility failed to protect the residents of the facility from neglect by staff of the facility for one (1) facility resident (Resident #1). The findings are: 1. On 8/31/09 during review of complaint intake report to the Department of Health revealed the following: Source states that complaint is regarding "abuse". Complainant source reports that Resident #1 could not breathe [sic] for on the previous Saturday at the facility due to lack of oxygen available at the facility for Resident #1. Review of Resident #1's file on 8/31/09 revealed that physician's orders on 1/29/08 included availability of an oxygen concentrator with E tanks as a back up source for Resident #1. 2. On 8/31/09 from 4:30 PM to 4:50 PM during general facility observation Resident #1 was observed to be sitting upright in his motorized wheelchair and yelling "help me". Observation of Resident #1's green oxygen tank indicator yielded that the arrow was in "the red zone" and out of oxygen. There was no staff visible in the vicinity during this observation and this surveyor had to seek assistance for Resident #1 during this 20 minute span to make the facility aware of the issue. 3. On 9/1/09 at 1:34 PM during interview,	A13	7.8.2.13 B(9) (1) Staff will complete In-Serv Training on 12/8 - 12/12/09 on regulations regard Abuse and Neglect of residents. Staff will also complete In-Serv Training regarding: + Medication Assistance + Employee Conduct + Reporting of Incidents, Abuse and Neglect of Residents. + Recognizing signs and systems of shortness of breath in residents. + Policies regarding emergency procedures note: Interview #2 is no longer employed by facility due to inappropriate behaviors toward residents & staff and not following company policies and procedures regarding resident care.	

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A13	Continued From page 9 interviewee #12 reports that Resident #1 could not breathe due to failure of the oxygen concentrator for this resident over the course of the previous week as well as lack of green tank oxygen at the facility during the previous weekend. Interviewee #12 stated that during this time, supervisory staff did not call 911 to assess Resident #1 even though he was experiencing breathing problems due to lack of oxygenation. However, interviewee #12 reports that during this time, Resident #1 made a phone call out of the facility. Interviewee #12 reports that neither supervisory staff present at the time nor other staff present at the time called 911 for assistance to Resident #1. Interviewee #12 reports that ultimately, Staff #1 was contacted regarding Resident #1. 4. On 9/1/09 at 2:00 PM during general facility observation Resident #1 was observed to be sitting upright in his motorized wheelchair. Observation of Resident #1's green oxygen tank indicator yielded that the arrow was in "the red zone". At 4:30 PM during observation Resident #1's tank green oxygen tank indicator yielded that the arrow was in "the red zone" and out of oxygen. 5. On 10/5/09 at 3:00 PM during interview, Interviewee #7 indicates noticing Resident #1's oxygen not being turned on in times past as well as lack of availability of the green tank oxygen for this resident. Interviewee #7 reports receiving a phone call from Resident #1 in 8/09 and reports that during that conversation, Resident #1 asked for a visit from the Interviewee because of "problems with oxygen that had caused all (personnel) to be in the room (and) not knowing if [sic] would make it through the night". Interviewee #7 reports that the facility has a	A13	(2) Director will investigate and survey staff and residents to determain if there are any other such incidents or related issues regarding residents care and treatment. (3) Director and/or Manager will on a weekly basis and by direct observation verbally survey residents and staff to ensure that residents needs are being met and that staff is following policies and procedures regarding: * Abuse + Neglect of Residents * Medication Assistance * Employee Conduct * Incident / Accident Reporting (4) First Inservice Training 12/8/09.	

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A13	Continued From page 10	A13		

history of "horrible communication" regarding Resident #1 and was never contacted about lack of oxygen for Resident #1. Similarly, Interviewee #7 reports never having received information about failure of the oxygen concentrator, lack of oxygen availability from the facility on the weekend of 8/29/09 from the facility. Interviewee #7 reports that on 10/4/09 Interviewee #2 reported to Interviewee #7 that Resident #1 had been "gasping" for air recently.

6. On 8/20/09 during interview, Interviewee #12 reported concerns that supervisory staff at the facility does not permit phone calls to family members or calls to 911 when incidents that may potentially impact resident health occur with a facility resident.

7. On 8/31/09 at 12:17 PM during interview Interviewee #8 reports that Interviewee #2 is responsible for ensuring that pills and oxygen are ordered and available for facility residents.

8. On 9/1/09 at 3:54 PM during interview with Interviewee #15, Interviewee #15 reports that Interviewee #2 is responsible for ensuring that pills and oxygen are ordered for residents.

9. On 9/1/09 at 7:47 PM during interview, Interviewee #13 reports that Interviewee #2 is the person who is in charge of ordering medications.

10. On 9/8/09 at 11:40 AM during interview, Interviewee #10 reports that Interviewee #2 is in charge of ordering (pills and oxygen).

11. On 9/1/09 at 6:38 PM during interview with Interviewee #14 regarding what to do when a resident's health status changes, Interviewee #14 stated that Interviewee #2 is notified.

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(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
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 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.	A36		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2134	A. BUILDING _____ B. WING _____	10/15/2009

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A36	Continued From page 12 (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 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	A36		

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A36	Continued From page 13 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: Refer to ~~7.8.2.36(C)~~ - Physician's Order for Medication Based on observation, record review and interview, the facility failed to follow physician medication orders for 1 resident (Resident # 5). The findings are: A. On 8/30/09 at 7:00 AM, during observation of the medication count with Staff #8 and Staff #2, Staff #2 told Staff #8 not to give Resident #5 any of the prescribed Hydrocodone tablets in the medication cart. B. On 8/30/09 at 7:00 AM, during interview Staff #2 stated that the caregiving staff had been instructed by Resident #5's family not to provide the medication to Resident #5. Staff #2 further stated that Resident #5 does ask (staff) [sic] for the medication. C. On 8/30/09 during review of Resident #5's medical record, there was no written order from Resident #5's physician noting discontinuation of Hydrocodone for this resident. Refer to 7.8.2.36(G) Staff assistance with medications provided and documented in accordance with state and federal laws	A36	7.8.2.36(C) (1) Facility will Review all Residents MARs to ensure that proper Physicians Orders are ~~Filed~~ Filed. Staff will follow all physicians orders regarding resident's medication. Staff will complete In-Service training regarding resident's Phy Orders, medication and assisting with medications. In-Serv all reg. for "Following Physicians Orders". (2) Facil. ty will Review all MARS to ensure that all correct phy's orders are properly filed and being followed. (3) Lead staff will on a daily basis ensure that resident are taking medication as prescribed by physician. Mang and or Director will on a weekly basis review MARs to ensure that residents MARs are correct physicians orders are being followed and that staff are following correct procedures.	

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A36	Continued From page 14 Based on observation record reviews and interviews, the facility failed to ensure that medications given to a resident were given by the person assisting (Resident #3). The findings are: A. On 8/19/09, during presurvey review of intake information, it was revealed that the complainant source was reporting that the facility "is not giving resident's their medications like they should [sic] and making staff pre-pour medications and leave them [sic]." B. On 9/1/09 at 3:00 PM, during observation of the medication pass, it was noted that Staff #10 prepoured a dose of Imodium (prescribed for treatment of episodic diarrhea) into a souffle cup and handed it Staff #2 to give it to Resident #3. Staff #10 was then observed to sign the Medication Administration Record without verifying if Resident #3 had received the medication. C. On 8/20/09 at 3:30 PM, during interview Staff #5 reported that supervisory staff at the facility have given directives to caregiving staff to pre-pour medications in advance of medication pass times. D. On 8/26/09 at 5:11 PM, during interview, Interviewee #11 reported witnessing pre-pouring of medications in the facility and that supervisory staff were aware that this was happening.	A36	(4) 12/8/09 7.8.2.36(E) (1) Facility will ensure that residents are receiving medications according to State Regulations. Staff will be instructed to assist residents in taking their medications according to physicians orders. Staff will complete In-Service training on * Assisting with Medications * Following Physicians Orders (2) Facility will review all other residents charts to ensure that MARs are correct, file contains updated Physicians orders, and that staff is correctly following and charting Physicians orders (3) Management will on a daily basis review residents MAR to ensure that policies regarding charting and Medication Assistance are being followed. (4) First In-Serv Training 12/8/09	

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