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 _____	C 02/21/2006

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 PRECEEDED 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 This was a complaint investigaiton survey that was conducted from 2/20/06-2/21/06. Four complaints were investigated. NM15511- SUBSTANTIATED with deficiencies cited. NM15845- UNSUBSTANTIATED with no deficiencies cited. NM14066- UNSUBSTANTIATED with no deficiencies cited. NM16589- UNSUBSTANTIATED with deficiencies cited.	A 01	A. With respect to the specific item cited: Resident #3 was admitted to the Reminiscence Unit on 1/20/05 with a history of arthritis; high blood pressure; early dementia, Alzheimer's type; and some difficulty of swallowing over the past six months. On July 7, 2005, Medication Care Manager (MCM) called doctor about sore throat. Zithromax Z-Pak prescribed. On 7/11/05, MCM called doctor's office that resident still complaining of sore throat despite Z-Pak. Called daughter-in-law to set up doctor appointment. Resident was taken to doctor who removed dentures. The resident expired on 7/16/06. B. With respect to how the community will identify residents with the potential to be affected by the identified concern: Residents who wear dentures by assessment or record review have the potential to be affected. C With respect to what systematic measures have been put in place to address the stated concern: The community will insure that all suspected cases or known incidences of resident abuse, neglect, exploitation, and mistreatment are reported. The community will also report any incident or unusual occurrence, which has or could threaten the health, safety, or welfare of the residents and staff to the Licensing authority and Adult Protective Services by the next business day. The community will complete Incident Reports per policy. The executive	
A33	7 NMAC 8.2.33 REPORTING OF INCIDENTS 7.8.2.33 REPORTING OF INCIDENTS: A. The facility must insure that all suspected cases or known incidents of resident abuse, neglect, exploitation, and mistreatment are reported. A facility must also report any incident or unusual occurrence which has or could threaten the health, safety, or welfare of the residents and staff to the Licensing Authority and Adult Protective Services (APS) by the next business day. In no instance may a facility delay a report to Adult Protective Services or to the Licensing Authority, while an internal investigation is being conducted. B. The facility is responsible for documenting all incidents, within five (5) days of the incident, and having on file, the following: (1) A narrative description of the incident. (2) Results of the facility's investigation. (3) The facility action, if any. [7-1-64, 9-15-70, 5-26-72, 7-11-86, 4-7-97; 7.8.2.33 NMAC - Rn 7 NMAC 8.2.33, 8-31-00] This REQUIREMENT is not met as evidenced by: Refer to 7.8.2.3 (A)	A33		

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A33	Continued From page 1 Based on record review and interview, the facility failed to report an incident of elopement and a incident of alleged neglect for 2 of 5 sampled residents (R#1, 3) to Health Facility Licensing and Certification by the next business day. The findings are: A. On 2/20/06 at 9:25 a.m. review of a Incident report for resident #1 revealed on 9/9/05 at 4:00 p.m. resident #1 was found at the intersection of Tramway and Comanche approximately 1.3 miles away from the facility. 1. Review of the Investigation report revealed that a police officer received several phone calls regarding a man [resident #1] who was having difficulty walking. The man had no identification except for some papers he had taken from another male resident at the facility. After investigation, the police officer determined that the unidentified man might be a resident at the facility. The officer returned resident #1 to the facility. 2. Resident #1 was non verbal and unable to seek help from anyone. Review of resident #1's chart revealed a diagnosis of severe Dementia and severe Alzheimers. 3. The Assisted Living Coordinator confirmed the details of the incident report and stated in interview on 2/21/06 that the facility was never aware until contacted by police that the resident was missing. B. On 2/21/06 at 1:10 p.m. during interview, the Assisted Living Coordinator stated "I don't believe it was reported to the Dept of Health. We don't have any documentation showing that DOH was notified." C. On 2/21/06 review of the Dept. of Health Complaint Intake Database revealed no self	A33	director or designee will be responsible for insuring that the proper agencies are contacted by the next business day. D. With respect how the plan of correction will be monitored: At the daily Stand-up Meeting and department manager meeting, resident issues are discussed. Any unusual occurrences or incident reports will be discussed. If they warrant reporting, they will be reported to the proper agency by the next business day. The executive director or his designee will insure the proper agencies are contacted.	

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A33	Continued From page 2 reported incident or narrative of the follow up investigation from the facility regarding resident #1. D. The facility failed to report to the state licensing authority and to complete an investigation into possible neglect of resident #3. On 2/20/06 at 11:45 a.m. review of the closed record revealed that resident #3 was admitted to the facility on 1/20/05 with a diagnosis of Alzheimers, Dementia and other multiple medical problems. Review on 2/20/06 of the 24-hour reports for resident #3 reveal that she increasingly complained of feeling ill. On 7/12/05 the resident was taken to the doctor who notified the facility that resident #3 had swallowed her dentures. The facility did not investigate this occurrence until the resident died four days later on 7/16/05. The incident was never reported to the licensing authority. Details are as follows: a. On 7/8/05 resident #3 was complaining of a sore throat and running a fever. b. On 7/9/05 resident #3 is still feeling sick c. On 7/10/05 resident #3 is not eating well and has been coughing a lot d. On 7/11/05 resident #3 isn't eating anything at all because her throat is still hurting e. On 7/12/05 resident #3 still complaining of a sore throat. Resident was taken to Dr. after which the facility was notified that resident #3 had swallowed her bottom dentures. Resident #3 had dentures removed by ENT and returned back to facility. f. On 7/13/05 resident "not eating good today" g. On 7/14/05 encouraging fluids, comfort measures only h. On 2/20/05 at 2:30 p.m. review of a Incident Report for resident #3 revealed, on the early morning of 7/16/05 at 3:26 a.m., resident #3 was found non-responsive, and staff was unable	A33	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. With respect to the specific item cited: Resident #1 had been admitted on 9/09/05 to the Reminiscence Unit (REM) at 1:00 pm, was last seen by staff at 2:30 pm, and was returned to the community at 4:00 pm. He was examined by the health care coordinator and the Reminiscence Coordinator upon return and had no injury. The resident has remained at the community and has not eloped again. Because this incident occurred during a special event, the executive director (ED) has directed that no new admissions would occur on a day that a large special event was occurring. This would give staff the opportunity to get to know the resident and recognize if the resident was leaving unauthorized. B. With respect to how the community will identify residents with the potential to be affected by the identified concern: All Reminiscence residents have the potential to be affected.	

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A33	Continued From page 3 to raise vital signs. Emergency services at 911, police and coroner were notified. E. On 2/21/06 at 1:10 p.m. during interview, the Assisted Living Coordinator confirmed that resident #3 swallowed her dentures, confirmed that an incident report was not created until 7/16/05 and stated "I don't believe it was reported to the Dept. of Health. We don't have any documentation showing that DOH was notified. We obviously called APS and they came out." F. On 2/21/06 review of the Dept of Health Complaint Intake Database revealed no self reported incident or narrative of the follow up investigation from the facility regarding resident #3.	A33	C. With respect to what systematic measures have been put in place to address the stated concern: The community faxed the DOH Incident Report, Sunrise Incident Report, and summary investigation to the Department of Health four (4) business days after the incident. (See attached). The community will insure that all suspected cases or known incidents of resident abuse, neglect, exploitation, and mistreatment are reported. The facility will also report any incident or unusual occurrence, which has or could threaten the health, safety, or welfare of the residents and staff to the Licensing authority and Adult Protective Services by the next business day. The community will complete incident reports per policy. The executive director or his designee will be responsible for insuring that the proper agencies are contacted by the next business day. D. With respect to how the plan of correction will be monitored: The ED issued a directive that no resident would be admitted to REM during a large special event. During routine rounds, the Lead Care Managers, the REM Coordinator, and the ED check the outside doors to insure they are locked.	