

Division of Health Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 5882	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 09/05/2024
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NAME OF PROVIDER OR SUPPLIER CAMINO RETIREMENT APARTMENTS	STREET ADDRESS, CITY, STATE, ZIP CODE 12101 LOMAS NE ALBUQUERQUE, NM 87112
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8 000	<p>Initial Comments</p> <p>The following deficiencies were cited during a complaint survey completed on 09/05/24 for the state requirements of NMAC 8.370.14, Regulations for Assisted Living Facilities for Adults.</p> <p>Complaint Intake NM [REDACTED] was investigated, and deficiencies were cited.</p> <p>Complaint Intake NM [REDACTED] was investigated, and deficiencies were not cited.</p> <p>Census: 88</p>	8 000	<p>This Plan of Correction is provided to assure resident safety and quality of care, and to meet regulatory requirements. It does not necessarily indicate admission or agreement with the survey conclusions or facts cited, and is not intended to establish a standard of care.</p>	
8 033	<p>8 NMAC 370.14.33 Resident Rights</p> <p>All licensed facilities shall understand, protect and respect the rights of all residents.</p> <p>A. Prior to admission to a facility, a resident and legal representative shall be given a written description of the legal rights of the resident, translated into another language, if necessary, to meet the resident's understanding.</p> <p>B. If the resident has no legal representative and is incapable of understanding his or her legal rights, a written copy of the resident's legal rights shall be provided to the most significant responsible party in the following order:</p> <ol style="list-style-type: none"> (1) the resident's spouse; (2) significant other; (3) any of the resident's adult children; (4) the resident's parents; (5) any relative the resident has lived with for six or more months before admission; (6) a person who has been caring for, or paying benefits on behalf of the resident; (7) a placing agency; (8) resident advocate; or (9) the ombudsman. <p>C. The resident rights shall be posted in a</p>	8 033		

Division of Health Improvement
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE



Executive Director

09/25/2024

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8 033	<p>Continued From page 1</p> <p>conspicuous public place in the facility and shall include the telephone numbers for the incident management hotline and for the state ombudsman program.</p> <p>D. To protect resident rights, the facility shall:</p> <ul style="list-style-type: none"> (1) treat all residents with courtesy, respect, dignity and compassion; (2) not discriminate in admission or services based on gender, sexual orientation, resident's age, race, religion, physical or mental disability, or nationality; (3) provide residents written information about all services provided by the facility and their costs and give advance written notice of any changes; (4) provide residents with a safe and sanitary living environment; (5) provide humane care for all residents; (6) provide the right to privacy, including privacy during medical examinations, consultations and treatment; (7) protect the confidentiality of the resident's medical record; (8) protect the right to personal privacy, including privacy in personal hygiene; privacy during visits with a spouse, family member or other visitor; and privacy in the resident's own room; (9) protect the right to communicate privately and freely with any person, including private telephone conversations and private correspondence; and the right to receive visits from family, friends, lawyers, ombudsmen and community organizations; (10) prohibit the use of any and all physical and chemical restraints; (11) ensure that residents: <ul style="list-style-type: none"> (a) are free from physical and emotional abuse neglect and misappropriation/or exploitation; (b) are free from financial abuse and misappropriation by facility staff or management; 	8 033		

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8 033	<p>Continued From page 2</p> <p>(c) are free to participate in religious, social, community and other activities and freely associate with persons in and out of the facility;</p> <p>(d) are free to leave the facility and return without unreasonable restriction;</p> <p>(e) are given a 15 calendar day, written notice before room transfers or discharge from the facility unless there is immediate danger to self or others in the facility;</p> <p>(f) have an environment that fosters social interaction and avoids social isolation;</p> <p>(g) or their surrogate decision makers, are informed of and consent to the services provided by the facility;</p> <p>(h) have the right to voice grievances to the facility staff, public officials, the ombudsmen, any state agency, or any other person, without fear of reprisal or retaliation;</p> <p>(i) have the right to have their complaints addressed within 14 calendar days or sooner;</p> <p>(j) have the right to participate in the development of their care plan/ISP;</p> <p>(k) have the right to choose a doctor, pharmacist and other health care provider(s);</p> <p>(l) have the right to participate in medical treatment decisions and formulate advance directives such as living wills and powers of attorney;</p> <p>(m) have the right to keep and use personal possessions without loss or damage;</p> <p>(n) have the right to manage and control their personal finances;</p> <p>(o) have the right to freely organize and participate in a resident association that may recommend changes in the facility's policies, services and management;</p> <p>(p) shall not be required to work for the facility;</p> <p>and</p> <p>(q) are protected from unjustified room transfers</p>	8 033		

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8 033	<p>Continued From page 3</p> <p>or discharge.</p> <p>E. The resident's rights shall not be restricted unless this restriction is for the health and safety of the resident, agreed to by the resident or the resident's surrogate decision maker and outlined in the resident's individual service plan. [8.370.14.33 NMAC - N, 7/1/2024]</p> <p>This REQUIREMENT is not met as evidenced by: 8.370.14.33 D 11 (a) Based on record review and interview, the facility failed to ensure for 1 (R #2) of 88 (R #'s 1-88) residents listed on the resident census (provided by the Executive Director (ED) on 09/03/24), were free from neglect. This deficient practice likely caused harm to R #2 due to the facility's failure to properly provide the correct medications to her (R #2).</p> <p>The findings are:</p> <p>A. Record review of complaint intake NM [REDACTED] (incident date 08/03/23) revealed:</p> <ol style="list-style-type: none"> Another resident's medications (approximately 9) were given to R #2 on top of [REDACTED] own medications. R #2 suffered moderate harm and was taken to the local Emergency Room (ER). <p>B. Record review of R #2's Managed Care Organization's (MCO's) progress notes revealed:</p> <ol style="list-style-type: none"> On 08/03/24, R #2 was seen in the hospital Emergency Room for accidental administration of another person's medications. Some of the additional medications R #2 received (on top of her own) were [REDACTED] R #2 presented as bradycardic (resting 	8 033	<p>8033. Medication error.</p> <p>The standard correction steps for any Med error were immediately implemented on 8/3/2023 when this Med error was discovered. These included notification of the resident's physician and family contacts; health assessment of the resident and provision of additional treatment as needed; and review/update of the resident's care plan. Camino also initiated a "self report" of this med error within indicated time requirements.</p> <p>The staff member involved in the error was counseled at the time of the error to only distribute medications to one resident at a time and shadowed to confirm safe practices.</p> <p>Additional In-service trainings were provided for all staff having medication duties by the Wellness Director during the week ending 9/30/2024 to reinforce our existing policies on medication safety, which include only filling/pouring medications for one resident at a time.</p> <p>The Wellness Director or delegate will conduct random Med Pass monitoring on all shifts at least monthly to assure that Med Passes are conducted in accordance with regulatory requirements and assuring that meds are not pre-filled for multiple residents</p>	9/30/24
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8 033	<p>Continued From page 4</p> <p>heart rate is less than 60 beats per minute): in the low 50's</p> <p>C. Record review of R #2's hospital ER progress notes dated 08/03/23, revealed:</p> <ol style="list-style-type: none"> 1. R #2 presented with accidental drug ingestion. R #2 had consumed [REDACTED] and [REDACTED] and a double dose of [REDACTED] (and another resident's dosage). 2. R #2's heart rate was in the low 50's. 3. R #2's laboratory analysis revealed: <ol style="list-style-type: none"> a) [REDACTED] (sodium level in blood was too low). b) [REDACTED] rapid, shallow breathing, that makes one feel like one is not getting enough air). 4. Clinical Impressions: Adverse effect of drug. 5. Emergency Room Triage Note revealed: <ol style="list-style-type: none"> a) Resident (R #2) was given [REDACTED] own medications and another resident's medications. b) R #2 stated that [REDACTED] was "feeling drunk." c) R #2 was bradycardic on arrival. <p>D. Record Review of Incident report completed by Direct Care Staff (DCS) #1 (dated 08/03/23 at 8:00 am) revealed:</p> <ol style="list-style-type: none"> 1. R #2 was given [REDACTED] own medication as well as another resident's medications in the facility hallway (medications not listed). 2. DCS #1 was the medication technician (MT) who made the medication error. 3. Poison control, R #2's provider, and MCO were notified by DCS #1. 4. R #2 was taken to the hospital ER on 08/03/23 at 9:00 am. <p>E. On 09/03/24 at 3:42 pm, during an interview with R #2, stated the following:</p>	8 033		
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8 033	<p>Continued From page 5</p> <p>1. The medication error occurred during the morning medication time (approximately 8:00 am) on 08/03/23.</p> <p>2. DCS #1 had pre-filled several pill cups for different residents, and had them lined up on the medication cart in the hallway.</p> <p>a) One resident was waiting for medications and another one was coming from the elevator when R #2 approached DCS #1 for [REDACTED] (R #2's) medications.</p> <p>b) R #2 was second in line at the hallway medication cart, and DCS #1 handed [REDACTED] a cup of medications.</p> <p>c) When R #2 received the pre-filled cup from DCS #1, R #2 told DCS #1 that it seemed like a lot more pills than normal, but DCS #1 told [REDACTED] that it was normal and gave the medications to R #2. R #2 said okay and took them then proceeded to the shuttle van to go to [REDACTED] appointment with her MCO nurse practitioner (NP).</p> <p>d) After R #2 left to the MCO, DCS #1 noticed the pill cups were accidentally reversed, and she immediately notified the MCO that she had made a medication error: R #2 had taken another resident's medications on top of [REDACTED] own.</p> <p>e) By the time R #2 arrived at the MCO, she (R #2) was feeling very euphoric/light headed, and they (MCO staff) rushed [REDACTED] into a room where three (3) Registered Nurses (RNs) took R #2's blood pressure. When the RN's asked R #2 to speak, [REDACTED] had garbled speech; worse than being drunk. R #2 had no idea whose medication [REDACTED] took and what the medication was. R #2's heart rate was extremely low, and [REDACTED] felt like [REDACTED] was floating.</p> <p>f) The MCO staff contacted Emergency Medical Services (EMS) and had R #2 taken to the hospital ER.</p> <p>g) R #2 stayed at the hospital for about five</p>	8 033		

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8 033	<p>Continued From page 6</p> <p>hours. At the hospital, they gave R #2 an intravenous (IV) and when they thought [redacted] was okay, they sent R #2 back to the facility.</p> <p>h) When R #2 returned to the facility, DCS #1 was almost in tears and apologized, stating that she felt bad for the mistake, and R #2 forgave her (DCS #1).</p> <p>G. On 9/03/24 at 3:52 pm, during an interview with the Executive Director (ED), stated the following:</p> <ol style="list-style-type: none"> 1. DCS #1 was rushing and overwhelmed because residents were coming up to her at the med cart in the hallway, asking for their medications, while she was giving medications to other residents and it caused her to be distracted. 2. DCS #1 made a medication error when she gave R #2 extra medications that belonged to another resident. 3. When DCS #1 discovered her medication error, she notified the ED, then called poison control, and R #2's NP. 4. DCS #1 was new and not that experienced. DCS took her medication assistance certification test in May 2023 and the incident had occurred in August 2023. 5. The facility did not change their medication assistance policy after this happened, because many residents are "anal" and want their medications upon request, so they try to accommodate their residents. <p>H. On 09/04/24 at 4:40 pm, during an interview with DCS #1, stated the following:</p> <ol style="list-style-type: none"> 1. On 08/03/24, DCS #1 made the medication error was the first time she had worked the long hallway (the long hallway has double the residents to serve compared to the short hallway-which is what she was used to). 2. DCS #1 was working alone, with no 	8 033		

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8 033	<p>Continued From page 7</p> <p>supervisor around.</p> <p>3. Another resident was getting medications when R #2 came to the hallway medication cart, asking for [REDACTED] medications, in the middle of DCS #1 trying to get the first resident's medications.</p> <p>4. DCS #1 knew that R #2 was trying to get out to go to [REDACTED] MCO appointment, so DCS #1 felt rushed and overwhelmed because she was trying to accommodate three different residents at once.</p> <p>5. DCS #1 gave R #1 [REDACTED] medications, and R #2 quickly took [REDACTED] medications then went to the shuttle van for [REDACTED] appointment at the MCO.</p> <p>6. About 15 minutes had passed when DCS #1 realized that she had given R #2 [REDACTED] medications and another resident's medications on top of [REDACTED] R #2's) own.</p> <p>7. DCS #1 notified her supervisor right away, then she called poison control and the MCO. The MCO sent R #2 to the hospital ER for treatment.</p> <p>8. DCS #1 stated that it was overwhelming and nerve-wracking to pass medications for so many residents in the long hallway. DCS #1 said it was chaotic to prepare her medications while residents would come up and ask for their medications at the same time.</p> <p>9. DCS #1 stated that she had expressed her concerns to management many times, but she didn't feel they listened.</p> <p>I. On 09/05/24 at 11:00 am, during an interview with R #2's NP, she stated the following:</p> <p>1. On 08/03/23, DCS #1 called the MCO, where the NP was working, and notified the NP that at 7:58 am, R #2 had been given another resident's medication on top of [REDACTED] own medications.</p> <p>2. At the MCO (on 08/03/23), R #2 told the NP that [REDACTED] It like blood was draining from [REDACTED] head and [REDACTED] couldn't feel [REDACTED] legs or feet.</p>	8 033		

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8 033	<p>Continued From page 8</p> <p>3. The MCO staff immediately called the Emergency Medical Services (EMS) and R #2 was transported to the hospital ER.</p> <p>4. According to the NP the following medications given in error to R #2 and could have caused injury or even death if R #2 had not been taken to the hospital ER on 08/03/23. Following were the extra medications given in error according to the NP to and the risks involved:</p> <p>a) [REDACTED] The NP's concerns were that R #2 has allergies to a similar beta blocker called [REDACTED] (used for high blood pressure). The risk of taking this medication was allergic reaction to the medication and hypertension (high blood pressure in the arteries). The hypertension could have caused R #2 to fall or cause death if [REDACTED] was too hypertensive.</p> <p>b) [REDACTED] The NP stated that the risk was liver failure if [REDACTED] of [REDACTED] was taken. The NP stated that R #2 had taken [REDACTED] dosage of [REDACTED] that was given in error. The [REDACTED] could have caused liver failure if the medication had not been flushed from [REDACTED] system.</p> <p>c) [REDACTED] The NP stated that the risk was an increase in hypotension (low blood pressure), acute kidney injuries/issues, and that R #2 could become hypovolemic (fluid overload in the body).</p> <p>d) [REDACTED] The NP stated that this is a dopamine agonist (treatment for movement disorders) for Parkinson's disease and R #2 does not have Parkinson's disease. The risk of R #2 taking the medication, was that it could cause a feeling of speedy, jittery, and anxious behaviors.</p> <p>e) [REDACTED] was given in error and was taken in addition to R #2's own [REDACTED]</p>	8 033		

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8 033	<p>Continued From page 9</p> <p>██████████ dosage. This medication is for neuropathy (nerve damage that causes numbness and chronic pain). The NP stated that the risk of the overdose was fatigue.</p> <p>f) ██████████ The NP stated that the risk of taking this in error is that it is Angio intensive (used to treat blocked/damaged blood vessels). This medication lowered R #2's blood pressure significantly and ██████████ was in a hypotensive state. The NP stated that if blood pressure goes too low, the person can die.</p> <p>g) ██████████ The NP stated that R #2 has an allergy to another diazide (medication that lowers fluid retention) and an allergic reaction was a concern. The NP stated that when she examined R #2, ██████████ couldn't move ██████████ legs. The NP also stated that the risk of taking this medication is that it lowers blood pressure significantly. The NP stated that when the blood pressure goes that low, it is not enough blood volume to feed organs and the risk was death if the blood pressure had gone too low.</p> <p>h) ██████████ (for overactive bladders). The NP could not find a significant risk with this medication.</p> <p>i) ██████████ The NP stated that R #2 had complained that ██████████ couldn't feel ██████████ head and this medication likely caused that. The NP stated that this medication is used to treat neuralgia's symptoms (stabbing burning/severe pain due to damaged nerves). The NP stated that the risk for taking this medication is that it causes light-headedness/slurring of words.</p>	8 033		
8 034	<p>8 NMAC 370.14.34 Custodial Drug Permits</p> <p>A facility with two or more residents that is licensed pursuant to this rule and that assists with</p>	8 034		

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8 034	<p>Continued From page 10</p> <p>self-administration or safeguards medications for residents shall have a current custodial drug permit issued by the state board of pharmacy.</p> <p>A. Procurement, labeling and storage: The facility shall provide assistance to the resident in obtaining the necessary medications, treatment and medical supplies as identified in the ISP. The facility shall procure, label and store medications for residents who require assistance with self-administration of medication in compliance with state and federal laws.</p> <p>(1) All medications, including non-prescription drugs, shall be stored in a locked compartment or in a locked room, as approved by the board of pharmacy and the key shall be in the care of the administrator or designee.</p> <p>(2) Internal medication shall be kept separate from external medications. Drugs to be taken by mouth shall be separated from all other delivery forms.</p> <p>(3) A separate, locked refrigerator shall be provided by the facility for medications. The refrigerator temperature shall be kept in compliance with the state board of pharmacy requirements for medications.</p> <p>(4) All medications, including non-prescription medications, shall be stored in separate compartments for each resident and all medications shall be labeled with the resident's name.</p> <p>(5) A resident may be permitted to keep his or her own medication in a locked compartment in his or her room for self-administration, if the physician's order deems it appropriate.</p> <p>(6) The facility shall not require the residents to purchase medications from any pharmacy.</p> <p>(7) Medical gases (oxygen) and equipment used for the administration of inhalation therapy and for resuscitative purposes shall comply with the</p>	8 034		

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8 034	<p>Continued From page 11</p> <p>national fire protection association (NFPA) 99.</p> <p>(8) A proof of use record shall be maintained separately for each schedule II through IV drug (controlled substances). The proof of use sheet shall document:</p> <p>(a) the type and strength of the schedule II through IV drugs;</p> <p>(b) the date and time staff assisted with self-administration;</p> <p>(c) the resident's name;</p> <p>(d) the prescriber's name;</p> <p>(e) the dose;</p> <p>(f) the signature of the person assisting with delivery of the medication; and</p> <p>(g) the balance of medication remaining.</p> <p>(9) Any remaining medication discontinued by a physician's order, or upon discharge or death of the resident shall be inventoried and moved to a separate locked storage container. Such discontinued medications shall be destroyed upon the next quarterly visit by the consulting pharmacist in accordance with 16.19.11.10 NMAC.</p> <p>(10) The record of medication destruction shall be signed by the administrator or designee and the pharmacist and shall be kept on file at the facility.</p> <p>B. Consulting pharmacist: The facility shall maintain records demonstrating that the consulting pharmacist provides the following oversight and guidance.</p> <p>(1) Reviews the medication regimen as needed, but at least quarterly/every three months, to determine that all medications and records are accurate and current. All irregularities shall be reported to the administrator of the facility and these irregularities shall be resolved by the administrator within 72 hours.</p> <p>(2) A system of records of receipt and disposition</p>	8 034		

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8 034	<p>Continued From page 12</p> <p>of all drugs in sufficient detail to enable an accurate reconciliation.</p> <p>(3) Consultation shall be 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.</p> <p>(4) The consulting pharmacist will be responsible for assuring that the facility meets all requirements for storage, labeling, destruction and documentation of medications as required by the state board of pharmacy, 16.19.11.10 NMAC and 8.370.14 NMAC. [8.370.14.34 NMAC - N, 7/1/2024]</p> <p>This REQUIREMENT is not met as evidenced by: 8.370.14.34 A (1) Based on record review, observation and interviews, the facility failed to ensure that the following physician-ordered medications were available for 2 (R #1 and R #2) of the 88(R #1 through R #88) resident reviewed for compliance, listed on the census provided by the Administrator on 09/03/24.</p> <p>This deficient practice could potentially affect the health, safety, and welfare of the 88 residents (R #1 through 88), listed on the resident census, provided by the Administrator on 09/03/24, if residents missed doses of their prescribed medications.</p> <p>The findings are:</p> <p>R #1</p> <p>A. Record review of R #1's physician order dated [REDACTED] 21, revealed R #1 was prescribed to take [REDACTED]</p>	8 034	<p>8034. Availability of Custodial Medications.</p> <p>The [REDACTED] listed as a PRN medication for R#1 was ordered and available on the Med Cart by 9/20/24. No requested PRN doses were missed during the period ending 9/20/2024.</p> <p>For R#2 the [REDACTED] was located at the resident's night stand in accordance with the doctor's order, instead of being kept in the med cart. No PRN doses were missed, since that medication was always available to R#2.</p> <p>The Assistant Wellness Manager, who is responsible for tracking and re-ordering medications as needed, was counseled on the requirement to continue to re-order all medications, including PRNs, unless and until the order is discontinued by the resident's physician. She was also counseled on the need to make follow-up calls on the status of any medication that is not delivered by the time the prior supply is exhausted, and to document the order dates for any medication with delayed delivery dates. This counseling was conducted on 9/23/2024 by the Wellness Director and Executive Director.</p> <p>The Assistant Wellness Director or delegate will conduct Cart Audits weekly to identify any missing Medications or other discrepancies from Doctor Orders and take immediate correction actions as needed. Med Staff will make a report to Supervisors of any discrepancies between the cart inventory and MAR records</p>	9/23/24

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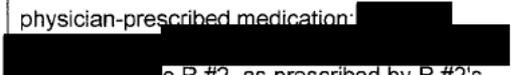
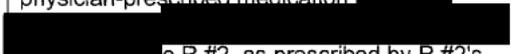
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8 034	<p>Continued From page 13</p> <p>[REDACTED]</p> <p>B. Record review of R #1's September 2024 Medication Administration Record (MAR) listed R #1's physician-ordered medication: PRN: [REDACTED]</p> <p>C. On 09/05/24 at 9:44 am, during an observation of a medication cabinet, R #1's physician-ordered medication: PRN: [REDACTED]</p> <p>D. On 09/05/24 at 9:44 am, during an interview, Direct Care Staff (DCS) #2 confirmed R #1's physician-ordered medication. PRN: [REDACTED] was not in the medication cabinet, and not available at the facility for the resident for a while (no specific to from dates) because the resident refuses to take them anyway, and the facility is attempting to discontinue (DC) medications that the resident refuses.</p> <p>R #2</p> <p>E. Record review of R #2's physician's order (dated 04/24/23), revealed that [REDACTED] Saliva stimulant) was prescribed to R #2.</p> <p>F. Record review of R #2's MAR dated September 2024, revealed that R #'s physician-prescribed medication: [REDACTED]</p> <p>G. On 09/05/24 at 9:50 am, during an observation of the medication cabinet, R #2's</p>	8 034		

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8 034	Continued From page 14  H. On 09/05/24 at 9:50 am, during an interview, DCS #2 confirmed that R #2's physician-prescribed medication:   o R #2, as prescribed by R #2's Primary Care Physician (PCP). DCS #2 stated that the medication was not available at the facility for the resident for a while (no specific to from dates) because the pharmacy had not provided it yet. DCS #2 was unable to provide order dates or evidence that the medication was ordered.	8 034		
8 035	8 NMAC 370.14.35 Medication Administration of medications or staff assistance with self-administration of medications shall be in accordance with state and federal laws. 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 from the physician, physician assistant or nurse practitioner and with entry into the resident's record. A. State board of nursing licensed or certified health care professionals are responsible for the administration of medications. Administration may only be performed by these individuals. B. Facility staff may assist a resident with the self-administration of medications if written consent by the resident is given to the administrator of the facility or the administrator's designee. If the resident is incapable of giving	8 035		

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8 035	<p>Continued From page 15</p> <p>consent, the surrogate decision maker named in accordance with New Mexico law may give written consent for assistance with self-administration of medications. All staff that assist with self-administration of medications shall have successfully completed a state approved assistance with self-administration of medication training program or be licensed or certified by the state board of nursing.</p> <p>C. PRN (pro re nada) medication: (1) Physician or physician extender's orders for PRN medications shall clearly indicate the circumstances in which they are to be used, the number of doses that may be given in a 24-hour period and indicate under what circumstances the primary care practitioner (PCP) is to be notified. (2) The utilization of PRN medications shall be reviewed routinely. Frequent or escalating use of PRN medications shall be reported to the PCP.</p> <p>D. Only a licensed nurse (RN or LPN) shall administer any medications or conduct any invasive procedures provided by the following routes: intravenous (IV), subcutaneous (SQ), intramuscular (IM), vaginal or rectal. Only a licensed nurse shall administer non-premixed nebulizer treatments.</p> <p>E. The facility shall have medication reference material that contains information relating to drug interactions and side effects on the premises. Staff that assist in the self-administration of medications shall know interactions or possible side effects that might occur.</p> <p>F. Medications prescribed for one resident shall not be used for another resident.</p> <p>G. Medication assistance record (MAR): For residents who are not independent and require assistance with self-administration, the facility shall have a MAR that documents the details of the residents' medication, including PRN and</p>	8 035		

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8 035	<p>Continued From page 16</p> <p>over-the-counter medication that is assisted with self-administration by qualified staff or administered to the resident by licensed or certified staff. The information in the MAR shall include:</p> <ul style="list-style-type: none"> (1) the resident's name; (2) any known allergies to medication that the resident has; (3) the name of the resident's PCP or the prescriber of the medication; (4) the diagnosis or reason for the medication; (5) the name of the medication, including the drug product brand name and the generic name; (6) notation if the medication is a schedule II-IV drug; (7) the dosage of the medication; (8) the strength of the medication; (9) the frequency or how often the medication is to be taken or given; (10) the route of delivery for the medication (mouth, eye, ear, other); (11) the method of delivery for the medication (pills, drops, IM injection, other); (12) the date that the medication was started or discontinued; (13) any change in the medication order; (14) pre-medication information (i.e., pulse, respiration, blood pressure, blood sugar) as required by the medication order; (15) the date and time that the medication is self-administered, administered with assistance or is administered; (16) the initials and signature of the person assisting with or administering the medication; (17) the desired results obtained from or problems encountered with the medication (pain relieved, allergic reaction, etc.); (18) any refused dose of medication; (19) any missed dose of medication; and 	8 035		

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8 035	<p>Continued From page 17</p> <p>(20) any medication error.</p> <p>H. No medication shall be stopped or started without specific orders from the primary care physician.</p> <p>I. If a resident refuses to take a prescribed medication, it shall be documented and the facility shall report it to the prescriber.</p> <p>J. A suspected adverse reaction to a medication shall be documented on the MAR and reported immediately to the PCP and the resident's surrogate decision maker. If applicable, emergency medical treatment shall be arranged. Documentation of the event shall be kept in the resident's record.</p> <p>K. Prescription medication, other than blister packs and unit dose containers, shall be kept in the original container with a pharmacy label that includes the following:</p> <ol style="list-style-type: none"> (1) the resident's name; (2) the name of the medication; (3) the date that the prescription was issued; (4) the prescribed dosage and the instructions for administration of the medication; and (5) the name and title of the prescriber. <p>L. Any medication that is removed from the pharmacy container or blister pack shall be given immediately and documented by the staff that assisted with the medication delivery.</p> <p>M. The facility shall report all medication errors to the physician, documentation of medication errors and the prescriber's response shall be kept in the resident's record.</p> <p>N. The facility shall develop and follow a written policy for unused, outdated, or recalled medications kept in the facility in accordance with 16.19.11.10 NMAC. [8.370.14.35 NMAC - N, 7/1/2024]</p> <p>This REQUIREMENT is not met as evidenced by:</p>	8 035		

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8 035	<p>Continued From page 18</p> <p>8.370.14.35 G (5, 7 and 8)</p> <p>Based on record review and interview, the facility failed to ensure for 1 (R #2) of 88 (R #1 through R #88) residents file reviewed for compliance that the medications listed on the Medication Administrative Record (MAR) contained:</p> <ol style="list-style-type: none"> 1. Both brand and generic name. 2. The dosage of the medication. 3. The strength of the medication. <p>These deficient practices could likely result in the 88 (R #1-88) residents listed on the resident census provided by the Administrator on 09/03/24, to be at risk of illness or harm if:</p> <ol style="list-style-type: none"> 1. Medication errors occur when a Direct Care Staff (DCS) accidentally gives the wrong medication to a resident if the name of the medication listed does not include both brand and generic names. 2. Medication errors occur when medications listed on the MAR do not list the dosage directions given by the prescriber. 3. Medication errors occur when medications on the MAR do not list the strength of the medication. <p>The findings are:</p> <p>A. Record review of R #2's September 2024 MAR revealed that both the brand and generic names were not included for the medication: [REDACTED]</p> <p>B. Record review of R #2's September 2024 MAR revealed that neither the strength nor dosage of the medication: [REDACTED] were listed on the MAR.</p>	8 035	<p>8035. Complete MAR records.</p> <p>The MAR record for R#2 was updated to include both the brand and generic name for The [REDACTED]</p> <p>The Assistant Wellness Manager was directed to review all medications listed on the MAR at the time of the order to insure that the MAR record includes the generic and brand names of medications (when available on the physician order) as well as insuring that the MAR includes the strength/dosage for all medication. This direction was included in the Counseling session of 9/23/2024. The Assistant Wellness Manager is scheduled to complete a the full review of all medication names and dosages/strengths to assure full compliance as of 9/27/2024.</p>	9/27/24

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8 035	<p>Continued From page 19</p> <p>C. On 09/05/24 at 9:50 am, during an interview with DCS #2, he confirmed the following:</p> <ol style="list-style-type: none"> Both the brand and generic name were not included on R #2's September 2024 MAR for the medication: [REDACTED] Both the strength or dosage were not included on R #2's September 2024 MAR for the medication: [REDACTED] 	8 035		