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	4113	A. BUILDING: _____ B. WING _____	C 03/02/2021

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THE WATERMARK AT CHERRY HILLS	6901 SAN VINCENTE AVE NE ALBUQUERQUE, NM 87109

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A 000	Initial Comments The following deficiencies were cited during an Initial/Complaint survey completed on 03/02/21 for the state requirements of 7 NMAC 8.2, Regulations for Assisted Living. Complaint #NM44961 was substantiated with deficiencies cited. Complaint #NM50325 was unsubstantiated with no deficiencies cited.	A 000		
A 026	7 NMAC 8.2.26 Individual Service Plan INDIVIDUAL SERVICE PLAN (ISP): An ISP shall be developed and implemented within ten (10) calendar days of admission for each resident residing in the facility. A. The ISP shall address those areas of need as identified in the resident evaluation and through staff observation. (1) The ISP shall detail the services that are provided by the facility as well as the services to be provided by other agencies. (2) The resident evaluation and the ISP shall be reviewed and if needed revised by a licensed practical nurse, registered nurse or a physician extender. (3) The ISP shall be reviewed and or revised at a minimum of every six (6) months or when there is a significant change in the resident ' s health status. B. The ISP shall include the following: (1) a description of identified needs as noted in the resident evaluation; (2) a written description of all services to 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;	A 026		

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A 026	Continued From page 1 (6) where the services will be provided; (7) expected goals and outcomes of the services; (8) documentation of the facility ' s determination that it is able to meet the needs of the resident; (9) the level of assistance that the resident will require with activities of daily living and with medications; (10) a crisis prevention/intervention plan when indicated by diagnosis or behavior; and (11) current orders for all medications, including those authorized for PRN usage. [7.8.2.26 NMAC - Rp, 7.8.2.26 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.26 Based on record review and interview, the facility failed to ensure for 1 (R #2) of 4 (R #s 1-4) residents whose individual service plans (ISPs) were reviewed for compliance, that they were completed within 10 days after admission to the facility. This deficient practice is likely to result in residents not receiving appropriate care/services upon admission if the Direct Care Staff (DCS) are not aware of what the resident's needs are. The findings are: A. Record review of R #2's individual service plan (ISP) dated 08/31/18, revealed that the ISP was not completed within 10-days after admission on 04/16/18. B. On 03/01/21 at 1:35 pm, during an interview with the Administrator, she confirmed that R #2's ISP was not completed prior to admission.	A 026		

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A 033	Continued From page 2	A 033		
A 033	7 NMAC 8.2.33 Resident Rights RESIDENT RIGHTS: All licensed facilities shall understand, protect and respect the rights of all residents. 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. 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: (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. C. The resident rights shall be posted in a conspicuous public place in the facility and shall include the telephone numbers for the incident management hotline and for the state ombudsman program. D. To protect resident rights, the facility shall: (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	A 033		

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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:
(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;
(c) are free to participate in religious, social, community and other activities and freely associate with persons in and out of the facility;
(d) are free to leave the facility and return without unreasonable restriction;
(e) are given a fifteen (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;
(f) have an environment that fosters social interaction and avoids social isolation;
(g) or their surrogate decision makers, are

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A 033	Continued From page 4 informed of and consent to the services provided by the facility; (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; (i) have the right to have their complaints addressed within fourteen (14) calendar days or sooner; (j) have the right to participate in the development of their care plan/ISP; (k) have the right to choose a doctor, pharmacist and other health care provider(s); (l) have the right to participate in medical treatment decisions and formulate advance directives such as living wills and powers of attorney; (m) have the right to keep and use personal possessions without loss or damage; (n) have the right to manage and control their personal finances; (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) shall not be required to work for the facility; and (q) are protected from unjustified room transfers or discharge. 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. [7.8.2.33 NMAC - Rp, 7.8.2.34 NMAC, 01/15/2010]	A 033		

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A 033	Continued From page 5 This REQUIREMENT is not met as evidenced by: 7.8.2.33 D (11) (a) 7.8.2.7 DEFINITIONS: . . . AW. "Neglect" means the failure to provide goods and services necessary to avoid physical harm, mental anguish or mental illness and is defined in the Incident Reporting Intake, Processing & Training Requirements, 7.1.13 NMAC. 7.1.13.7. DEFINITIONS: . . . T. "Neglect" means the failure of the caretaker/staff to provide basic needs of a person, such as clothing, food, shelter, supervision and care for the physical and mental health of that person. Neglect causes, or is likely to cause, harm, or death to a person. Based on record review and interview, the facility failed to ensure the safety and welfare for 1 (R #1) of 1 (R #1) resident identified as not receiving oxygen as needed and as physician ordered. This deficient practice did result in the resident with hypoxia (low oxygen at room air) to suffer harm and death, because he did not receive oxygen as required per physician orders to maintain adequate oxygen levels. The findings are: A. Record review of R #1's Resident Notes dated 05/05/20, revealed the following: 1. R #1 had a fall, with no injuries noted, and O2 sats were found to be in the 70's. 2. Nurse sat R #1 up and put oxygen cannula (tubing) into his mouth because resident stated he was having trouble breathing through his nose.	A 033		

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A 033	Continued From page 6 3. Nurse stayed with R #1 for 45 minutes and spoke to his son regarding R #1's current hypoxia (oxygen deficiency). 4 At the end of the 45 minutes R #1's O2 sats were between 88-93% on 5 Liters per minute (LPM) 5. R #1's son agreed for Nurse to request an Home Heath Registered Nurse (HHRN) visit and R #1's oxygen will remain on 5 liters nasal cannula per orders. 6. Resident will remain on hourly rounds and Direct Care Staff (DCS) were made aware. Record review of R #1's Medication List/Physician Orders dated 03/26/19 revealed that R #1: 1. Code status was CPR/Full-Code (wants actions taken to persurve life). 2. Had Chronic Lung Disease (lung disorders characterized by increasing breathlessness) and was on oxygen. 3. Physician orders/medication list stated his oxygen order was for 4 liters per minute (lpm). Record review of R #1's latest Comprehensive Assessment dated 09/04/19 revealed that R #1 managed his own oxygen. Record review of the facility Incident Report received by the Licensing Authority on 05/22/20 revealed the following information for R #1: 1. On 05/21/20, R #1: a. Stated "I would commit suicide if it were not against my religion" to the Home Health Registered Nurse (HHRN), during her visit, which she reported to the facility. b. R #1 was overheard by a kitchen staff member verbalizing that he wanted to die". c. R #1 was on 1-hour wellness checks 2. On 05/22/21:	A 033		

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a. R #1 was experiencing increased confusion prior to his death.

b. R #1 entered another resident's room by mistake at approximately 10:30 am and was escorted back to his room by the Resident Services Coordinator (RSC) around 11:00 am.

c. DCS ? (connie) arrived at R #1's room at approximately 11:05 am and found R #1 was on the floor, unresponsive, and his chair was on it's side.

e. DCS called 911, alerted the Nurse to reported R #1's room immediately and she began CPR (ardiopulmonary Resuscitation - is an emergency lifesaving procedure performed when the heart stops beating).

f. R #1 began to vomit and was turned on his side.

g. Emergency Medical Services (EMS) arrived and stated that the resident appeared deceased.

h. The local Fire Department notified the local Police Department. The Police Department arrived on scene and was advised by the Office of the Medical Investigator (OMI) and R #1's body was picked up by OMI at approximately 2:15 pm.

i. The facility had made mulitiple calls to R #1's Primary Care Physician (PCP) and family regarding his increased confusion.

Record review of DCS #? (Maxima) written statement dated 05/22/20 revealed the following:

1. R #1 was doing well and took his morning medications.

2. 10 minutes after DCS #? walked out of R #1's room, he called for help, was very agitated, looking for his keys, and the remote control for hsi TV.

3. Later R #1 walked out of the room and looking for his pants, saying his keys were in them, he was very confused walking fown the

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hallway.

4. Around 11:00 am, a DCS called on the radio stating she needed help in R #1's room. DCS #? (Maxima) and DCS #13 went ot assist and when they walked in the room R #1 was on the floor, called DCS #?, (Mariah) the Resident's Sevice Coordinator (RSC) was also in the room and 911 was called immediately.

Record review or the facility Follow-Up report received by the Licensing Authority on 05/26/20 revealed the following information:

1. Facility determined that R #1 was in distress before he was found and that his O2 (Oxygen) saturation (The extent ot which an element in blood is staturated with oxygen) had been low prior to death.

2. DCS involved were placed on Administrative Leave until the investigation was completed.

3. The facility will ensure that all residents with a "Do Not Recesitate" order will have an alert on their door. Not sure if needed

4: DCS will be retrained in responding to an unresponsive resident and baseline vital signs. Not sure if needed

Record review of facility's timeline of events received by the Licensing Authorty on 05/26/21 revealed the following:

1. 8:55am-Resident received medication pass.

2. 9:08am-Resident received visit from Server to take lunch order.

3. 9:43am-Resident was visited by RSC. Notes indicate that R #1's oxygen level was between 72-77 and he was showing increased confusion and agitation.

4. 10:03am-Resident was visited by Direct Care Staff (DCS #4) who reported that she had

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helped R #1 get back in his recliner and that he continued to show signs of confusion.

5. 10:15am-Resident was visited by Housekeeper (HK). Her statement indicated that R #1 was banging on the arm of his chair, she left the door proped open to be able to check on him.

6. 11:00am-Community Registered Nurse (RN) was contacted by DCS #? (Maxima), requesting RN come to R #1's room.

7. 11:10am-DCS call 911 and RN began CPR.

8. 11:27am-Local Fire Department arrived on scene.

9. 11:45am-Local Police Department Arrived on scene.

10. 2:15pm-R #1's body wa picked up by the Office of the Medical Examiner (OMI).

C. Record review of DCS #4's (Yolanda S.) written statement dated 05/26/20 revealed the following:

1. DCS #4 was in R #1's room at approximately 9:48 am. Resident was confused, looking for his keys.

2. DCS #4 brought R #1 his keys. R #1 was on his knees, still looking for his keys.

3. R #1 got up and DCS #4 assisted him in getting back in his recliner.

4. DCS #4 stated that R #1 still had oxgyen on when she left the room.

D. Record review of DCS #? (Connie Lightfoot) written statement dated 05/22/20 revealed that around 11:00 am, she walked into R #1's room and he was on the floor between his chair and the bed. She notified DCS #13 that she needed

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A 033	Continued From page 10 assistance as soon as possible D. Record review of DCS #13's written statement dated 05/26/20, revealed that on 05/22/20: 1. He heard another DCS on the walkie (radio) that help was needed in R #1's room as soon as possible. 2. DCS #13, DCS #?, (Maxima) and the RSC entered the roon and saw that R #1 lying on the floor on his left side. 3. DCS #13 was going to turn R #1 over and do CPR right away, but was told by the RSC not to touch the body, 4. DCS #13 listeded to the RSC, because she was the Assistant to the Director of Nursing. The RSC told him to call the Nurse right away. 5. The nurse arrived and did CPR right away. E. Record review of Housekeeper (HK) (Luz Contreras) written statement dated 05/26/21 revealed the following: 1. HK entered R #1's room about 10:45 am, to check on him. 2. R #1 was in his chair, had his oxygen on, and was banging on the arm of his chair. 3. HK left the room and placed garbage in the door so they would not hear R #1 banging. 4. HK went to another room and heard more banging on the chair. 5. HK heard a loud band and then DCS #? (Connie) came running down the hall. Record review of the Nurse's written statement dated 05/26/21 revealed the following: 1. On 05/22/20 the RN was on a conference call at 10:30 pm, While on the call the RSC came to the RN's office and waited at the door, but did not alert her to there was a possible emergency or any sense of urgency to step away from the	A 033		

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call. AT 10:41am received a text from RSC to let her know when she was done with her call, please. RN responded back saying she was done.

2. At approximately 11:00 am, Nurse received a call from DCS #? (Maxima) who stated you should come to R #1's room. Nurse asked if she needed to bring her stescope, DCS #? (Maxima) said, Yes, bring it.

3. RN arrived at R #1's room at about 11:05-11:10 am, found DCS #? (Maxima) DCS #13, and RSC in the room surrounding the resident. R #1 was unresponsive, pale and cold to the touch, and had a large amount of vomit from his mouth and nose.

4. Nurse asked if anyone had called 911, they all said no. Nurse instructed DCS #? (Maxima) to call 911.

5 Nurse asked if R #1 was a DNR or was a full code. RSC arrived back in the room and reported that R #1 was a full code.

6. Nurse instructed everyone to leave the room, cleaned R #1's face and mouth, and began chest compressions, after 30 compressions, Nurse checked for heartbeat /breathing. There was none found. Nurse bagan compressions again until EMS arrived. During the event, Nurse wa never alerted to oxyen stats as low as RSC reported/

Record review of meeting notes dated 05/26/20 revealed, that the following:

1. The Administrator and Nurse had a meeting with the RSC regarding the occurances with R #1 on 05/22/20.

2. The RSC was asked if she had put R #1's oxygen on before she left R #1's room at approximately 9:45 am. RSC stated that she had but R #1's oxygen on and set it to 1 liter.

3. RXC was asked it she had returned to

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check on R #1, as she said she would. ESC stated that she did return to R #1's room "in abou

E. Record review of meeting notes dated 05/27/21 with Administrator, Nurse, and DCS #13 revealed the following:

1. DCS #13 was propted to go to R #1's room when DCS #? (Connie) called on the walkie/radio saying come to R #1's room as soon as posible. DCS #13, DCS #? (Maxima), and RSC all walked into the room together.

2. DCS #13 knew that R #1 was having problems with his Oxyen, DCS were doing hourly checks on him.

3. When asked if anyone checked for a pulse/breath, DCS #13 stated "No. We just saw the throw up".

4. When asked if DCS #13 or anyone considered starting CPR, DCS #13 stated, I was gonna turn him, but the RSC said "Don't touch him". "I just listened to her. I didn't know he was a full code. He was purple and cold. It was too late".

5. When asked if R #1 was wearing his O2 (oxygen), DCS #13 stated that when he went in the room, R #1 was not wearing it and the cannula (tubing) was on the floor.

/orRecord review of meeting notes dated 05/27/21 with Administrator, Nurse, and DCS #? (Connie Lightfoot) revealed the folllowing:

1. When asked what prompted DCS #?? stated she was doing trash rounds, she did not hear a bang and did not run down the hallway.

2. When asked if DCS #? or anyone check for a pluse/breath? DCS #? stated she was shaking him and called on the walkie for help to come as soon as possibe. "I thought I saw his shirt moving. He was non-responsive". RSC went to R #1 and knelt down next to him and did

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE WATERMARK AT CHERRY HILLS	6901 SAN VINCENTE AVE NE ALBUQUERQUE, NM 87109

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not see if she took his pluse. RSC stated "he's gone".

3. When asked if DCS #? or anyone considered beginning CPR? Why or Why not? DCS #? stated, "No because I was thought he was on hospice. I am CPR/First Aid certified. It expires in December."

4. When asked about the O2.oxygen? DCS #? stated "It was on him because I put it on him when he got back to his room after being in his neighbor's apartment. I don't think he had it on when I found him unresponsive".

Record review of meeting notes dated 05/28/21 with HK, Administrator, and Nurse revealed the following:

1: In HK's statement dated 05/26/21, she stated that she had entered R #1's room at 10:45am, but the key card report showed the HK entered the room at 10:15 am. HK stated it must have been 10:15 am when she entered the room and put the trash can in the door.

2. When asked if HK peeked in to see the resident, did she think he was in distress or needed help? HK stated that she thought R #1 was mad.

3. When HK was asked, why dindn't you tell anyone? HK stated "I thought he was just mad. He was really quite".

4. When HK was asked, where she was when she heard the bang? HK stated that she was cleaning another room.

5. When HK was asked what she did next? HK stated that she walked out to hallway, went back into R #1's room again, and saw he was on the floor, HK heard someone running and left the room.

6. When HK was asked, "you left the room and didn't see anyone coming? Why didn't you tell anyone"? Hk stated "she got scared and did

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A 033	Continued From page 14 not see who went in or out". 7. When HK was asked if R #1 had his O2 (oxygen) on? HK stated that she "did not see if he did or not". 8. When HK was asked to clairfy that she didn't see DCS #? (Connie) running down the hallway? HK stated that she did not see DCS #? (Connie), in the hallway,"she just heard someone. I thought I heard someone running out of his room. I thought they were going to get help." 9. When HK was asked what happen after that? HK stated that she just stayed in the halllway for about 6-7 minutes later, the other staff started to come. 2. Resident Services Coordinator checked oxygen levels and found levels at 72-77 on room air and provided breathing exercises. No documentation showed oxygen was provided to resident, or no urgency to provide oxygen by Resident Services Coordinator. I found this in a record review of the RSC written statement and it is referred to again in finding F. 3. Documentation showed that oxygen levels were checked, but no oxygen was provided due to Hypoxia (low oxygen levels). Can you ftell me	A 033		

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where this Incident Report is in the W-drive. I can only find the 5/5/20 report.

B. On 03/02/21 at 3:15 pm, during an interview with the Administrator, she confirmed that the facility Resident Services Coordinator, Housekeeper and Direct Care Staff (DCS) did not provide oxygen and/or Emergency Services for up to 3 hours of his death, which would be considered adequate care. I did not find this statement in yours or Eriks notes.

1. Facility staff failed to Provide Is this the word the Admin used? care, facility staff failed to provide needed oxygen to resident. What kind of care did they not provide?

2. Take responsibility to provide needed oxygen to resident.

3. Facility staff did not provide Resident with emergency care for approximately 3 hours up to residents death. This should be your final finding.

C. Record review of R#1's Medication list dated 03/19/19 for 4 L (Liters) oxygen which resident managed on his own, no Physician orders were provided by facility. Was this actually on the incident report or does it need to be a separate finding? Changed to new finding.

D. Record review of said door fob report proved that 30-minute checks were not completed. Where is this report-I could not find it in the W-Drive.

E. Record review of R #1's medication list (dated 03/19/19) revealed that all the resident was on 4 Liters (Liters) of oxygen no scheduled time, only documentation stating that resident will manage his own oxygen.

F. Record review of facility's Resident Services

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A 033	Continued From page 16 Coordinator's written statement from staff member who went into resident's room and checked resident's oxygen level, staff member stated that she assisted resident with breathing exercises, on statement Resident Services Coordinator never mentioned that she placed oxygen on resident.	A 033		
A 035	7 NMAC 8.2.35 Medication MEDICATIONS: 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 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. C. PRN (pro re nada) medication.	A 035		

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A 035	Continued From page 17 (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. 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. 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. F. Medications prescribed for one resident shall not be used for another resident. 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 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: (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;	A 035		

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A 035	Continued From page 18 (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 (20) any medication error. H. No medication shall be stopped or started without specific orders from the primary care physician. I. If a resident refuses to take a prescribed medication, it shall be documented and the facility shall report it to the prescriber. J. A suspected adverse reaction to a medication shall be documented on the MAR and reported immediately to the PCP and the resident's	A 035		

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A 035	Continued From page 19 surrogate decision maker. If applicable, emergency medical treatment shall be arranged. Documentation of the event shall be kept in the resident's record. 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: (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. 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. 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. 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 (AS AMENDED). [7.8.2.35 NMAC - Rp, 7.8.2.35 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.35 G (5) Based on record review and interview the facility failed to ensure for 3 (R #s 2-4) of 3 (R #s 2-4) residents whose Medication Administration Records (MARs) were reviewed for compliance	A 035		

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that they included both the brand and generic names for all medications. This deficient practice could likely result in the residents being at risk of harm, if the Direct Care Staff (DCS) who assist residents with the self-administration of medications do not know or recognize the generic/brand names of the medications and errors occur due to this vital information missing on the MAR. The findings are:

A. Record review of R #2's February, 2021 MAR revealed that it did not include both the brand/generic names for:
1. Colace/docusate - (Constipation)
2. Divalproex DR/Depakote - (Mood)
3. Ferrous Sulfate/Iron - (low iron supplement)
4. Gabapentin/Neurontin - (Nerve Pain)
5. Mirtazapine/Remeron - (Psychotropic)
6. Hydrocodone-Acetaminophen/Lortab - (Pain)
7. Baclofen/Lioresal - (Muscle Spasm)
8. Citralopram/Celexa - (Anxiety)

C. Record review of R #3's February, 2021 MAR revealed that it did not include both the brand/generic names for:
1. Levothyroxine Sodium/Synthroid - (Thyroid)
2. Aldronate Sodium/Fosamex - (Osteoporosis)
3. Fish Oil Omega-3/Omega 3 fatty acids - (Supplement)
4. Docusate Sodium/Colace - (Constipation)

D. Record review of R #4's February 2021 MAR revealed that it did not include both the brand/generic names for:
1. Mementine HCL - (Alzheimers)
2. Metoprolol Succinate ER (Beta Blocker)

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A 035	Continued From page 21 3. Lorazepam/Ativan - (Anxiety) 4. Acetaminophen/Tylenol (Pain) E. On 03/05/21 at 3:15 pm, during an interview with the Administrator, she confirmed that the February, 2021 MARs for R #s 2-4 did not include both the Brand/Generic names for the above listed medications.	A 035		