STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	4029	A. BUILDING: _____ B. WING _____	R-C 02/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALBUQUERQUE UPTOWN ASSISTED LIVING, INC	7611 INDIAN SCHOOL RD NE ALBUQUERQUE, NM 87110

(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 000}	Initial Comments The following deficiencies were cited during a revisit/follow-up survey completed on 02/21/24 for the state requirements of NMAC 7.8.2, Regulations for Assisted Living Facilities for Adults. Resident Census-[redacted]	{A 000}		
{A 017}	7 NMAC 8.2.17 Staff Training STAFF TRAINING: A. Training and orientation for each new employee and volunteer that provides direct care shall include a minimum of sixteen (16) hours of supervised training prior to providing unsupervised care for residents. B. Documentation of orientation and subsequent trainings shall be kept in the personnel file at the facility. C. Training shall be provided at orientation and at least twelve (12) hours annually, the orientation, training and proof of competency shall include: (1) fire safety and evacuation training; (2) first aid; (3) safe food handling practices (for persons involved in food preparation), to include: (a) instructions in proper storage; (b) preparation and serving of food; (c) safety in food handling; (d) appropriate personal hygiene; and (e) infectious and communicable disease control; (4) confidentiality of records and resident information; (5) infection control; (6) resident rights; (7) reporting requirements for abuse, neglect or exploitation in accordance with 7.1.13 NMAC; (8) smoking policy for staff, residents and visitors; (9) methods to provide quality resident care;	{A 017}	The Facility understands and will abide by the state rules on staff training. Moving forward a new hire will do 16 hours of shadowing, 12 hours of orientation trainings. Then the new hire moves forward to the required annual training. Beginning from day of hire and ending on day of hire. Required annual trainings from day of hire to include 12 hours of annual trainings,12 hours of Alzheimer's & Dementia and 6 hours of Hospice. Moving forward all annual trainings will be completed annually from date of hire to date of hire. (DCS) will continue producing their annual trainings every week. The annual trainings will be monitored by the (HM) to ensure that all (DCS) is providing their trainings weekly.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

Donna Bully V. Garcia 3-12-2024

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{A 017}	Continued From page 1 (10) emergency procedures; (11) medication assistance, including the certificate of training for staff that assist with medication delivery; and (12) the proper way to implement a resident ISP for staff that assist with ISPs. D. If a facility provides transportation to residents, employees of the facility who drive vehicles and transport residents shall have training in transportation safety for the elderly and disabled, including safe vehicle operation. [7.8.2.17 NMAC - Rp, 7.8.2.17 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: 7.8.2.17 B C (2, 4-8, 10-11) This is an uncorrected deficiency from a survey dated 06/12/23 Based on record review and interview, the facility failed to ensure: 1. The Direct Care Staff (DCS) completed all twelve (12) hours of orientation and annual training required by regulation. 2. Documentation of the completed trainings were maintained onsite and available for review. These deficient practices could likely result in the [redacted] residents listed on the resident census, provided by the Owner on 02/15/24, to be at risk of harm if they are receiving care and services by DCS who have not received the required trainings. The findings are: A. Record review of the House Manager's (HM) (hire date 11/17/17) training file revealed no	{A 017}	House Manager (HM) has completed 12 hours of Orientation trainings as of Feb. 22, 2024. (HM) is currently working on her 12 hours annual trainings required by the state. (HM) has set up an in-house class in (incident reporting) on March 20-2024 with the DOH. The Facility has scheduled Alzheimer's, Dementia & Hospice trainings through the NMHCA.	

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{A 017}	Continued From page 2 documentation of completing the required annual trainings in the following areas: 1. Smoking policy for staff, residents, and visitors. 2. Emergency procedures 3. Medication assistance, including the certificate of training for staff that assist with medication delivery B. Record review of DCS #1's (hire date 11/09/23) training file revealed no documentation of completion that DCS #1 completed required orientation trainings in the following areas: 1. Confidentiality of records and resident information. 2. Infection control 3. Resident rights 4. Reporting requirements for abuse, neglect, or exploitation in accordance with 7.1.13 NMAC 5. Smoking policy for staff, residents, and visitors. 6. Emergency procedures C. Record review of DCS #3's (hire date 01/18/24) training file, revealed no documentation of that DCS #3 completed the required orientation training in first aid. D. On 02/19/24 at 3:30 pm, during an interview with the Owner, Administrator, and HM confirmed there was no documentation available for review because: 1. HM did not complete the (12) hours of annual training in all required areas . 2. DCS #1 did not complete the (12) twelve hours of orientation training in all required areas. E. On 02/19/24 at 4:19 pm, during an interview,	{A 017}	DCS#1's has completed the required orientation training in first aid, as of 2-29-2024. DCS#1 is currently working on the required annual trainings, as well as the required Alzheimer's & Dementia annual trainings. The facility has an in-house training (incident reporting) on March 20, 2024. DOH will be leading the class. Moving forward DCS#1 will continue with her annual trainings from day of hire. DCS#3 has completed all required. orientation trainings as of 2-22-2024 DCS#3 is currently working on all annual required trainings, as well as all required trainings in Alzheimer & Dementia. The facility has an in-house training (incident reporting) on March 20, 2024. DOH will be leading the class. Moving forward these trainings will all be done from day of hire to day of hire. per the state regs.	2/29/2024

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{A 017}	Continued From page 3 the Owner confirmed that DCS #3 did not complete the required first aid training at orientation, therefore, there was no documentation available to review.	{A 017}	Moving forward The Facility understands & agrees to do ISP's 10 days after admission, not 15 days after admission. This will keep us in compliance with the state.	
{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; (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	{A 026}	The Administrator has created a new ISP form to fit our needs and state regulations. The form will include but not limited to goals & outcomes, Agency, if the Resident is on a special agency, who will provide services when & how often services will be rendered, how & where services will be provided, it will also include the med list, including PRN meds for the resident. Current ISP's have been corrected as per state regulation 7NMAC8.2.26. Moving forward all ISPs will be done in accordance with the state regs.	

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{A 026}	Continued From page 4 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 A (1) B (1, 3, 4-7, and 11) This is an uncorrected deficiency from a survey completed on 06/12/23 Based on record review and interview, the facility failed to ensure for [redacted] residents whose Individual Service Plans (ISP's) were reviewed for compliance that theft were completed within ten (10) days after admission and addressed the following: 1. Services provided by the facility and the services to be provided by outside agencies. 2. A description of identified needs as noted in the resident evaluation. 3. Who will provide the services. 4. When or how often the services will be provided. 5. How the services will be provided. 6. Where the services will be provided. 7. Expected goals and outcomes of the services 8. Current orders for all medications, including those authorized for PRN (As needed-pro re nata) usage. These deficient practices could likely result in	{A 026}	Moving forward the (HM) will ensure that all ISP's for resident's include but not limited to: Services provided by any outside agency, A description of needs as noted int the Eval, who, when, and how services will be rendered, goals & outcomes, current meds including PRN.	

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{A 026}	Continued From page 5 residents not receiving the care and services needed or achieving the desired goals and outcomes because the Direct Care Staff (DCS) need to know what care/services they or other outside agencies are to provide. The findings are: Findings regarding ISPs not completed within 10-days A. Record review of R #1's Individual Service Plan (ISP) dated 01/21/24, revealed that the ISP was not developed and implemented within 10 days after the admission on [redacted] B. On 02/21/24, at 2:30 pm, during an interview, the owner confirmed R #1's ISP was not completed developed within 10 days after admission. Findings regarding ISPs with missing information C. Record review of R #1's ISP dated [redacted]24, revealed that the ISP did not include: 1. Expected goals and outcomes of the services 2. Current medication orders, including those authorized for [redacted] usage. D. Record review of R #2's ISP dated [redacted]24, revealed that the ISP did not include: 1. Expected goals and outcomes of the services 2. Current medication orders including those authorized for PRN usage. E. Record review of R #3's ISP dated [redacted]24, revealed that the ISP did not include: 1. A description of identified needs noted as	{A 026}	R#1's ISP was not completed 10 days after admission, it was completed 15 days. after admission. It was the facilities misunderstanding. This has been corrected going forward to do the ISP 10 days after admission. R#1's ISP has been updated and corrected to include, goals & outcomes, current medication order, including PRN. Outside agency, service, who what and where services will be performed. R#2's ISP-The facility has created a new ISP form to include goals & outcomes, outside agencies, current medications including PRN. Who were when services will be rendered. R#3's (ISP) The facility has created a new ISP form to include but not limited to: services provided, outside agency, goals & outcomes, current medications including PRN. Outside agencies, if any. Who what & where services will be rendered. Any needs noted in the Evaluation.	3/6/2024

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{A 026}	Continued From page 6 follows in the resident evaluation dated [redacted]'24: [redacted] 2. Who will provide services (wound care) 3. When or how often will wound care be provided 4. Where will the wound care will be provided 5. Expected goals and outcomes of services. 6. Current medication orders, including those authorized for PRN usage. F. On 02/21/24, at 2:30 pm, during an interview, the Owner confirmed that: 1. R #1's ISP dated [redacted]'24 was not developed and implemented within 10- days from the date of admission on [redacted] 2. R #s 1-3 ISPs did include all information required by regulation.	{A 026}	R#3's ISP has been updated and corrected to include: a description of identified needs noted as follows in the resident eval. Pressure sore on the left ankle & buttocks. Who & where will the services be provided, expected goals & outcomes, current medication orders including PRN meds.	3/6/2024
{A 034}	7 NMAC 8.2.34 Custodial Drug Permits CUSTODIAL DRUG PERMITS: A facility with two (2) or more residents that is licensed pursuant to this rule and that assists with self-administration or safeguards medications for residents shall have a current custodial drug permit issued by the state board of pharmacy. 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	{A 034}		

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{A 034}	Continued From page 7 with state and federal laws. (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. (2) Internal medication shall be kept separate from external medications. Drugs to be taken by mouth shall be separated from all other delivery forms. (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. (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. (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. (6) The facility shall not require the residents to purchase medications from any particular pharmacy. (7) Medical gases (oxygen) and equipment used for the administration of inhalation therapy and for resuscitative purposes shall comply with the national fire protection association (NFPA) 99. (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: (a) the type and strength of the schedule II through IV drugs; (b) the date and time staff assisted with self-administration;	{A 034}		

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{A 034}	Continued From page 8 (c) the resident ' s name; (d) the prescriber ' s name; (e) the dose; (f) the signature of the person assisting with delivery of the medication; and (g) the balance of medication remaining. (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. (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. B. Consulting pharmacist. The facility shall maintain records demonstrating that the consulting pharmacist provides the following oversight and guidance. (1) Reviews the medication regimen as needed, but at least quarterly/every three (3) months, to determine that all medications and records are accurate and current. All irregularities shall be reported to the administrator of the facility and these irregularities shall be resolved by the administrator within seventy-two (72) hours. (2) A system of records of receipt and disposition of all drugs in sufficient detail to enable an accurate reconciliation. (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. (4) The consulting pharmacist will be responsible for assuring that the facility meets all	{A 034}		

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{A 034}	Continued From page 9 requirements for storage, labeling, destruction and documentation of medications as required by the state board of pharmacy, 16.19.11.10 NMAC and 7.8.2 NMAC. [7.8.2.34 NMAC - Rp, 7.8.2.35 NMAC, 01/15/2010] This REQUIREMENT is not met as evidenced by: This is an uncorrected deficiency from a survey completed on [redacted]23 7.8.2.34 A Based on record review, observation, and interview, the facility failed to ensure for [redacted] residents whose medications were reviewed for compliance, that: 1. Their medications were available at the facility for use by the resident. 2. Medications had not been substituted with a generic brand, in which the ingredients did not match what was prescribed by the physician. These deficient practices could likely result in the residents to be at risk of harm, injury, or death if: 1. Prescribed medications are not available to be taken when needed. 2. Medications were substituted with generic brands that do not include the same ingredients and the name brand medication that was ordered by the physician. The findings are: Findings for R #1 A. Record review of R #1's physician's orders, revealed the following medications were ordered: 1. On [redacted]/24, [redacted] (PRN [as	{A 034}	Meds had been ordered but not delivered on February 19, 2024, when the Med cart was observed. Medications for R#1's and R#4's has been corrected by the Dr.'s We have current med orders for both. Med orders match prescription and our MAR. Moving forward the (HM) is responsible for ordering meds with sufficient time for delivery, so that the resident has all meds ready and available when needed. The (HM) along with the nurse will work together in ordering all the meds. (HM) will continue to make sure all meds including PRN match the Dr.'s orders, if the family brings in any meds, meds ordered by the nurse must all match before administering.	2/29/2024

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{A 034}	Continued From page 10 needed]): [redacted] affected area 4 times per day (QID), for 2. On [redacted]24, [redacted] 3. On [redacted]24, [redacted] 4. On [redacted]23, [redacted] B. On [redacted]24 at 2:25 pm, during observation of the medication cart, it was revealed: a) PRN: [redacted] was not in the medication cart. b) [redacted] was not in the medication cart. c) PRN: [redacted] was not in the medication cart. d) [redacted] were in the cart instead of 140 mg as ordered by the Physician. C. On 02/19/24, at 2:25 pm, during an interview, the House Manager (HM) confirmed the following: 1. PRN: [redacted] was not in the cart or available to R #1. 2. [redacted] was not in the cart or available to R #1. 3. PRN: [redacted] was not in the cart or available to R # 1. 4. [redacted] was the incorrect dosage [redacted] D. On 02/19/24, at 3:30 pm, during an interview, the Owner and Administrator confirmed: 1. PRN: [redacted] was not in the cart or available to R #1. 2. [redacted] was not in the cart	{A 034}		

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{A 034}	Continued From page 11 or available to R #1. 3. PRN: [redacted] was not in the cart or available to R # 1. 4. [redacted] was the incorrect dosage [redacted] E. On 02/21/24, at 1:18 pm, during an interview, R #1's Nurse Practitioner (NP), she confirmed: 1. PRN: [redacted] is a [redacted] and it was prescribed for R #1 to use for [redacted] If the medication is unavailable, the resident would not have relief from [redacted] 2. [redacted] was prescribed for [redacted] and without it, R #1's [redacted] 3. PRN: [redacted] was prescribed for [redacted] and without it, R #1's [redacted] may cause [redacted] 4. Only the NP or PCP (Primary Care Physician) can change the [redacted] prescription dosage; the facility or POA (Power of Attorney) should contact the NP or PCP for any changes. Findings for R #4 F. Record review of R #4's physician's order revealed the following medications were ordered on [redacted]23: 1. PRN: [redacted] 2. [redacted] 3. [redacted]	{A 034}		

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	4029	A. BUILDING: _____ B. WING _____	R-C 02/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALBUQUERQUE UPTOWN ASSISTED LIVING, INC	7611 INDIAN SCHOOL RD NE ALBUQUERQUE, NM 87110

(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 034}	Continued From page 12 [redacted]	{A 034}		

G. On [redacted]'24, at 2:25 pm, during observation of the medication cart, it was revealed that the following medications were not in the medication cart:

1. PRN: [redacted]
2. [redacted] (Had been substituted with a generic brand that did not match the prescribed medication)
3. [redacted]

H. On 02/19/24, at 2:25 pm, during an interview with the HM, she confirmed the following:

1. PRN: [redacted] was not in the cart
2. [redacted] was not in the cart and had been substituted with a generic brand, and the ingredients did not match what was prescribed.
3. [redacted] was not in the cart.

I. On 02/19/24, at 3:30 pm, during an interview, the Owner confirmed that:

1. PRN: [redacted] was not in the cart or available to R #4
2. [redacted] was substituted with a generic brand and ingredients did not match what was prescribed.
3. [redacted] was not in the cart or available to R #4.

J. On 02/21/24, at 9:19 am, during an interview with R #4's [redacted] she confirmed the following:

1. PRN: [redacted]

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{A 034}	Continued From page 13 prescribed medication was not available. 2. [redacted] was not in the cart and was substituted with a generic medication, and the ingredients did not match what was prescribed. 3. [redacted] a. Discontinued by the R #4's PCP or prescriber of the medication and removed from the MAR. b. Documentation of the physician's order to discontinue the medication should be maintained in R #4's medication file.	{A 034}		
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	A 035		

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A 035	Continued From page 14 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. (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	A 035		

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A 035	Continued From page 15 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; (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	A 035		

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A 035	Continued From page 16 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 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]	A 035		

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A 035	Continued From page 17 This REQUIREMENT is not met as evidenced by: 7.8.2.35 Based on record review, observation, and interview, the facility failed to ensure for [redacted] residents that medications were not changed without an order from the physician, physician assistant (PA) or nurse practitioner (NP). This deficient practice could likely result in the residents being at risk of harm if medications are not given as ordered by the physician. The findings are: Findings related to R #1 A. Record review of R #1's physician orders dated [redacted]/23, revealed that [redacted] B. On [redacted]24, at 2:25 pm, during observation of the medication cart revealed that a different dosage of [redacted] was available in the cart for R #1. C. On [redacted]/24, at 2:25 pm, during an interview, the House Manager (HM) confirmed that the medication dosage for the [redacted] should be [redacted] but the Power of Attorney (POA) brought [redacted] and: 1. HM decided to provide R #1 with [redacted] [redacted] was afraid of an overdose if [redacted] were to provide [redacted] 2. HM did not notify the POA or NP of her	A 035	The facility along with R#1's NP have corrected the med order for Zinc. Currently R#1 is on 50 mg of Zinc once a day. This order came in on Feb. 29th . The POA has been notified of the change order. It is understood by the facility that only R#1's NP is the only one who can make med order changes. The (HM) is responsible for making sure all meds brought in by the family, ordered by the nurse all match the Dr.'s order before putting them in the med cart and administering.	2/29/ 2024

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A 035	Continued From page 18 decision to change the dosage. 3. R #1's NP provided no change of order to reflect a dosage change for the [redacted] D. On 02/21/24, at 1:18 pm, during an interview with R #1's NP, [redacted] confirmed that [redacted] was prescribed to R #1 as a supplement and: 1. It should be given as prescribed. 2. Dosage changes or prescription changes should be discussed with the NP. 3. Only R #1's NP or PCP can change a prescription. Findings for R #4 E. Record review of R #4's physician's orders dated [redacted] 23, revealed that [redacted] was ordered as a supplement. F. On [redacted] 24, at 2:25 pm, during observation of the medication cart revealed the following: 1. Generic medication [redacted] (physician ordered) and did not contain the same ingredients as the name brand [redacted] The following label ingredients for generic medication were: [redacted] B. [redacted] [redacted] 2. [redacted] (physician ordered) label ingredients were: a. [redacted] b. [redacted] c. Other ingredients (not measured):	A 035	R#1's Florastar as of Feb.22, 2024, has been updated, changed & ordered by R#'s Physician. The order is now: OTC probiotic. Acetaminophen in the cart. Metformin is in the cart. Moving forward the Facility will ensure that all meds are in the cart. Florastar was replaced with a Dr. order with OTC probiotic. the order, prescription and our MAR all match up.	

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A 035	Continued From page 19 i. [redacted] ii. [redacted] G. On [redacted]/24, at 2:25 pm, during an interview, the House Manager (HM), confirmed that the prescribed medication, [redacted] was substituted with a generic medication called [redacted] without a order from R #4's physician.	A 035		