STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	325066	A. Building B. Wing	05/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bloomfield Nursing and Rehabilitation Center	803 Hacienda Lane Bloomfield, NM 87413

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47899 This is a past noncompliance. Based on record review and interview, the facility failed to ensure nursing staff demonstrated competency in skills and techniques necessary to safely administer medications to residents for 1 [Licensed Practical Nurse (LPN #1)] of 4 [LPN #1, LPN #2, Registered Nurse (RN) #1, and Certified Medication Assistant (CMA) #1] employees sampled for training. This deficient practice likely resulted in R #1 receiving another resident's medication, which resulted in R #1 being admitted to the hospital on 03/22/24 for accidental overdose and hypotension (low blood pressure). The findings are: A. Record review of the facility's Medication Management Clinical procedures, undated, revealed safe practices for giving medicines. Clinicians are required to follow policies and standards of practice when giving medicines. Staff directed to review the five rights of administering medicine: 1. The right person, 2. The right medicine, 3. The right dose, 4. The right route, 5. The right time. B. Record review of the facility's Complaint Narrative Investigation: A Follow-up Report (5 day), undated, revealed upon interview with LPN #1, she reported having pre-poured the medications in a cup, become distracted, and handed the medications to R #1 instead of R #2. LPN #1 reported she immediately realized she handed the medications to the wrong resident. Resident #1 did not ingest all of the medications, so she retrieved the remaining medications in the Sharp's container. RN #1 did not report the medication error to the physician or the Director of Nursing (DON). During a follow-up interview several days later, LPN #1 said she gave R #1 Prilosec (medication used for heart burn) and lisinopril (a medication used to lower blood pressure). C. Record review of the R #1's change of condition for medication error, dated 3/22/24, revealed the following: (continued on next page)

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F 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	1. On 03/22/24 at 5:46 am, staff documented R #1's blood pressure as 117/65 mmHG (millimeters of mercury; Normal blood pressure is 120/80 mmHG.) 2. On 03/22/24 at 10:37 am, staff documented R #1's blood pressure as 80/46 and sent the resident out to the emergency room (ER). D. Record review of R #1's hospital records, dated 03/22/24, revealed: 1. On 03/22/24 at 3:58 pm, R #1 was evaluated at the ER. 2. Chief Complaint: LPN accidentally gave the patient the wrong medications, hypotensive. 3. History of Present Illness: Patient is a [AGE] year-old-male in a nursing home with no significant past medical history besides dementia. Patient came in the Emergency Department (ED) after he was accidentally provided with the wrong patient medication. Medication list from R #2 included lisinopril (used to lower blood pressure), isosorbide (used for heart related chest pain, heart failure, and esophageal spasms), Lasix (used to treat fluid retention and high blood pressure), prazosin (used to treat high blood pressure), metformin (used to treat diabetes type 2). Patient was found to be hypotensive as a result, and he was transferred to the ED here. Patient did not have any other complaints, falls, or pain. Patient denied any complaint. He denied any headache, blurred vision, abdominal pain, chest pain, or shortness of breath. Telemetry (vital sign machine) showed normal blood pressure, normal saturation on room air (oxygen in the blood), ED reached out to Poison Control who recommended the addition of comprehensive metabolic panel (CMP; a blood test that measures 14 substances in the blood) and an electrocardiogram (EKG; a test that records the electrical signals in the heart, helps detect heart problems, and monitors heart health) later in the evening. Patient admitted for observation to monitor for many medication side effects that might arise. 4. At 3:58 pm, R #1's blood pressure was 115/55 mmHG. 5. Assessment: Medication overdose, hypotension. Patient noted to be hypotensive after receiving home medication of another patient. 6. Plan: Repeat CMP and EKG per Poison Control recommendations. Get physical therapy to evaluate the patient in the morning. 7. On 03/23/24 at 1:12 pm, R #1 was admitted overnight for observation to monitor of any medication side effects. He remained stable without any overnight events. He will be discharged to the nursing home. E. Record review of LPN #1's competency assessment record revealed the following: 1. Initial training and competency (the application and demonstration of appropriate knowledge, skills, behaviors, and judgment in a clinical setting) on medication administration completed on 03/24/2022. 2. Re-education competency completed on 01/26/24. (continued on next page)

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F 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	F. On 05/07/24 at 2:37 pm, during an interview with the DON, he stated LPN #1 confused R #1 and R #2, who sat in two different places in the dining room. The DON stated the LPN #1 handed R #1 the medication and then she saw R #2 who was supposed to receive the medication. He stated R #1 was ambulating between the 100 and 200 hall towards the front office, on 03/22/24 at approximately 10:30 am, when he got dizzy and fell . He said a housekeeper saw the resident trying to get up from the floor by using the handrails in the hallway. The DON stated staff kept R #1 on the floor, because the resident was still dizzy. He said the housekeeper ran to his nurse, and his nurse evaluated R #1. The DON stated LPN #1 went to Unit Manager (UM) #1 and reported the medication error that occurred at breakfast in the dining room, and LPN #1 reported she gave R #1 a multivitamin and that was all. He said staff called Emergency Medical Services (EMS). He said by the time EMS arrived R #1's vital signs were back to his baseline, and R #1 went to the hospital for an overnight observation. The DON stated, during the facility's investigation, LPN #1 reported R #1 only received a multivitamin. Further investigation revealed she had given a Prilosec and lisinopril. The DON stated LPN #1 has been written up for pre-pouring medications on a previous occasion. G. On 05/08/24 at 8:26 am, during an observation with RN #1 while she passed medications, RN #1 reviewed the medications for R #3, asked R #3 his name, checked the medication, the route, the dosage, and time. RN #3 watched R #3 take his medication. RN #1 documented the medication she gave to R #3. H. On 05/08/24 at 3:31 am, during observation and interview, RN #1 passed medication to R #4. RN #1 asked the resident his name, checked the medication, the route, the dosage, and time. RN #3 stated R #4 had a crush medication order. RN #3 watched R #4 take his medication. RN #3 stated if the resident was unable talk or give his name then she could compare the resident to the photo that was in the resident's medical record. RN #3 said she did not go off the name on the door of a resident's room, because another resident might be in there and answer to the name. RN #3 said if she was unsure about the right resident she would ask another nurse or teammate that might know who the resident was before she gave the medications. RN #1 stated they had an in-service on the seven rights of medication administration on 03/25/24. I. On 05/08/24 at 11:56 am, during an observation and interview with CMA #1 during a medication pass, CMA #1 checked medication with the order on the computer, identified the right resident, the right medication, right route, right dose, and right time. CMA watched R #5 take her medication. CMA #1 stated if she was unsure of the identity of a resident then she would ask another nurse or look at the resident photo that was in the resident's medical record. CMA #1 stated she attended an in-service recently on the rights of medication administration on 03/25/24. J. On 05/08/24 at 12:17 pm, during an interview with the DON, he stated new staff shadow a senior nurse (a nurse in the facility longer than others.) During this time, it would depend on the new nurse's knowledge of the system and how comfortable they were using the electronic medical record program. The DON stated new staff shadow for a maximum of three days on the medication cart, in order to allow them to get to know the residents and the electronic medical record program. The DON stated staff complete a competency annually, and the facility had one in early 2024 for medication pass. The DON stated staff have not reported any other medication errors since he became DON on 01/12/24, and he was not aware of any other medication errors. (continued on next page)

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F 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	K. On 05/09/24 at 830 am, during observation and interview with LPN #2 during a medication pass, the LPN checked the medication to the order, confirmed the right route, right dose, right time, and asked the resident his name. LPN #2 stated if this was a resident that he did not know then he would ask the resident to say their name and date of birth. LPN #2 stated if the resident could not tell him the information, then he would take the resident back to his cart to look at the picture in the resident's medical record. LPN #2 stated he could also get another staff who knew the resident to confirm the resident's identity. LPN #2 stated they have been getting in-serviced on the right of medication administration, and the education was in March 2024. Based on the facility's investigation of the medication error the following interventions were implemented and placed in an Improvement Action Plan: 1. LPN #1 was immediately suspended pending investigation for delayed notification of medication error. Completed 03/22/24. 2. All residents on LPN #1's assignment for 03/22/24 were evaluated for changes in status and screened for concerns related to their medication to rule out the potential of other medication errors. All resident audits were completed by nursing staff. The residents did not have changes from their baseline. 3. All nurses and CMAs to be educated on the five rights of medication administration related to resident identification. In-service on 03/24/24 and ongoing. 4. Random medication administration observations to be completed by DON or Designee three times per shift for four weeks. Evaluate and bring results to Quality Assurance Performance Improvement (QAPI; this is a data driven and proactive approach to quality improvement) monthly until determination of stop. Start date 03/22/24 and ongoing. 5. LPN #1 was terminated from the facility on 03/22/24 and turned into the New Mexico Board of Nursing on 03/24/24.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0760 Level of Harm - Actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47899 This is past noncompliance. Based on record review, observation, and interview, the facility failed to ensure residents are free of any significant medication errors for 1 (R #1) of 7 (R #1, R #3, R #4, R #5, R #6, R #7, and R #8) residents reviewed for neglect, when nursing staff failed to administer medication to the correct resident. This deficient practice likely resulted in R #1 experiencing adverse (unwanted, harmful, or abnormal) side effects and admission to the hospital. The findings are: A. Record review of the facility's Complaint Narrative Investigation: A Follow-up Report (5 day), undated, revealed upon interview with LPN #1, she reported having pre-poured the medications in a cup, become distracted, and handed the medications to R #1 instead of R #2. LPN #1 reported she immediately realized she handed the medications to the wrong resident. Resident #1 did not ingest all of the medications, so she retrieved the remaining medications in the Sharp's container. RN #1 did not report the medication error to the physician or the Director of Nursing (DON). During a follow-up interview several days later, LPN #1 said she gave R #1 Prilosec (medication used for heart burn) and lisinopril (a medication used to lower blood pressure). B. Record review of R #1's face sheet revealed the following diagnosis: - Unspecified dementia, unspecified severity, with other behavioral disturbance (characterized by a general decline in cognitive abilities that impacts a person's ability to perform everyday activities). - Vascular dementia, unspecified severity, with other behavioral disturbances (a condition caused by a lack of blood that carries oxygen and nutrients to the brain. It causes problems with reasoning, planning, judgement, and memory). - Benign prostatic hyperplasia with lower urinary tract symptoms (known as an enlarged prostate. Created the frequent and urgent need to urinate). C. Record review of R #1's electronic Medication Administration Record (eMAR) revealed staff administered the following medication to the resident on 3/22/24 in the morning: 1. Tobrex ophthalmic solution (eye antibiotic), 0.3%. Instill two drops in left eye, four times a day, for conjuntivits for seven days. Order started on 03/18/24. 2. Zrytec (allergy medication) oral tablet, 10 milligrams (MG). Give one tablet once a day for itching. D. Record review of the Change of Condition form (CIC) dated 10/22/24 revealed the following: 1. On 03/22/24 at 10:36 am, Licensed Practical Nurse (LPN) #1 called R #1's daughter to report R #1 would be going to the emergency room (ER) for an evaluation due to R #1 received another resident's medications along with his own during morning medication pass. (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Few	2. R #1 was hospitalized for one day and placed under observation. E. Record review of R #1's nursing notes, written by LPN #1, revealed: 1. On 03/22/24 at 10:42 am, R #1 had a drop in vital signs and was sent to the Emergency Department (ED) for evaluation. The resident's vital signs were: - At 9:45 am, blood pressure (B/P; normal B/P is 120/80) was 83/49, respiratory rate (RR; normal rate is 12 to 20) was 17, heart rate (HR; normal rate 60 to 100) was 66, temperature (normal rate 97 to 99 degrees) was 97.7 degrees, oxygen saturation (sats; oxygen in the blood. Normal range is above 88%.) was 97% on room air (RA). - At 10:30 am, B/P was 80/46, RR 12, HR 80, temperature 97.7, and sats 96% on RA. 2. On 03/22/24 at 11:20 am, staff checked the medications left in the cup that was handed to R #1 against medications cards to determine if any were given. Only Prilosec was missing from the medication cup. Due to low blood pressures R #1 had later, staff suspected hypertensive medication was ingested. R #1 was sent to the ER. Medications handed to resident in the medication cup were carvedilol (heart failure), 12.5 Milligrams (MG); furosemide (help with water retention/ blood pressure), 40 MG; isosorbide mononitrate extended release (used for heart related chest pain, heart failure, and esophageal spasms), 30 MG; lisinopril (reduces blood pressure), 5 MG; metformin (used to treat diabetes type 2), 500 MG; multivitamin with minerals, Prilosec (medication to reduce stomach acid), 20 MG; Steglatro (Diabetes Management), 5 MG. F. Record review of R #1's hospital records, dated 03/22/24, revealed: 1. On 03/22/24 at 3:58 pm, R #1 was evaluated at the ER. 2. Chief Complaint: LPN accidentally gave the patient the wrong medication, hypotensive. 3. History of Present Illness: Patient is a [AGE] year-old-male in a nursing home with no significant past medical history besides dementia. Patient came in the Emergency Department (ED) after he was accidentally provided with the wrong patient medication. Medication list from R #2 included lisinopril, isosorbide, Lasix (used to treat fluid retention and high blood pressure), prazosin (used to treat high blood pressure), metformin. Patient was found to be hypotensive as a result, and he was transferred to the ED here. Patient did not have any other complaints, falls, or pain. Patient denied any complaint. He denied any headache, blurred vision, abdominal pain, chest pain, or shortness of breath. Telemetry (vital sign machine) showed normal blood pressure, normal saturation on room air (oxygen in the blood), ED reached out to Poison Control who recommended the addition of comprehensive metabolic panel (CMP; a blood test that measures 14 substances in the blood) and an electrocardiogram (EKG; a test that records the electrical signals in the heart, helps detect heart problems, and monitors heart health) later in the evening. Patient admitted for observation to monitor for many medication side effects that might arise. 4. At 3:58 pm, R #1's blood pressure was 115/55 mmHG. 5. Assessment: Medication overdose, hypotension. Patient noted to be hypotensive after receiving home medication of another patient. (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Few	6. Plan: Repeat CMP and EKG per Poison Control recommendations. Get physical therapy to evaluate the patient in the morning. 7. On 03/23/24 at 1:12 pm, R #1 was admitted overnight for observation to monitor of any medication side effects. He remained stable without any overnight events. He will be discharged to the nursing home. G. On 05/07/24 at 2:37 pm, during an interview with the DON, he stated LPN #1 confused R #1 and R #2, who sat in two different places in the dining room. The DON stated the LPN #1 handed R #1 the medication and then she saw R #2 who was supposed to receive the medication. He stated R #1 was ambulating between the 100 and 200 halls towards the front office, on 03/22/24 at approximately 10:30 am, when he got dizzy and fell . He said a housekeeper saw the resident trying to get up from the floor by using the handrails in the hallway. The DON stated staff kept R #1 on the floor, because the resident was still dizzy. He said the housekeeper ran to the resident's nurse, and the nurse evaluated R #1. The DON stated LPN #1 went to Unit Manager (UM) #1 and reported the medication error that occurred at breakfast in the dining room, and LPN #1 reported she gave R #1 a multivitamin and that was all. He said staff called Emergency Medical Services (EMS). He said by the time EMS arrived R #1's vital signs were back to his baseline, and R #1 went to the hospital for an overnight observation. The DON stated, during the facility's investigation, LPN #1 reported R #1 only received multivitamin. Further investigation revealed she had given R #1 Prilosec and lisinopril. The DON stated LPN #1 has been written up for pre-pouring medications on a previous occasion. The DON stated his expectation for any medication error was for staff to report it to the DON. He said he also expected staff would report what medications were given to a resident in error. H. On 05/08/24 at 8:26 am, during an observation with RN #1 while she passed medications, RN #1 reviewed the medications for R #3, asked R #3 his name, checked the medication, the route, the dosage, and time. RN #3 watched R #3 take his medication. RN #1 documented the medication she gave to R #3. I. On 05/08/24 at 3:31 am, during observation and interview, RN #1 passed medication to R #4. RN #1 asked the resident his name, checked the medication, the route, the dosage, and time. RN #3 stated R #4 had a crush medication order. RN #3 watched R #4 take his medication. RN #3 stated if the resident was unable talk or give his name then she could compare the resident to the photo that was in the resident's medical record. RN #3 said she did not go off the name on the door of a resident's room, because another resident might be in there and answer to the name. RN #3 said if she was unsure about the right resident she would ask another nurse or teammate that might know who the resident was before she gave the medications. RN #1 stated they had an in-service on the seven rights of medication administration on 03/25/24. J. On 05/08/24 at 11:56 am, during an observation and interview with CMA #1 during a medication pass, CMA #1 checked medication with the order on the computer, identified the right resident, the right medication, right route, right dose, and right time. CMA watched R #5 take her medication. CMA #1 stated if she was unsure of the identity of a resident then she would ask another nurse or look at the resident photo that was in the resident's medical record. CMA #1 stated she attended an in-service recently on the rights of medication administration on 03/25/24. (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Few	K. On 05/08/24 at 12:17 pm, during an interview with the DON, he stated new staff shadow a senior nurse (a nurse in the facility longer than others.) During this time, it would depend on the new nurse's knowledge of the system and how comfortable they were using the electronic medical record program. The DON stated new staff shadow for a maximum of three days on the medication cart, in order to allow them to get to know the residents and the electronic medical record program. The DON stated staff complete a competency annually, and the facility had one in early 2024 for medication pass. The DON stated staff have not reported any other medication errors since he became DON on 01/12/24, and he was not aware of any other medication errors. L. On 05/09/24 at 830 am, during observation and interview with LPN #2 during a medication pass, the LPN checked the medication to the order, confirmed the right route, right dose, right time, and asked the resident his name. LPN #2 stated if this was a resident that he did not know then he would ask the resident to say their name and date of birth. LPN #2 stated if the resident could not tell him the information, then he would take the resident back to his cart to look at the picture in the resident's medical record. LPN #2 stated he could also get another staff who knew the resident to confirm the resident's identity. LPN #2 stated they have been getting in-service on the right of medication administration, and the education was in March 2024.