

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 325119	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/21/2024
NAME OF PROVIDER OR SUPPLIER Advanced Health Care of Albuquerque		STREET ADDRESS, CITY, STATE, ZIP CODE 2701 Richmond Drive NE Albuquerque, NM 87107	

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)
<p>F 0580</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35632</p> <p>Based on record review and interview, the facility failed to notify the physician for 1 (R #1) of 3 (R #1, R #2 and R #3) residents when staff did not administer multiple doses of heart medication to R #1 as ordered. If the facility is not notifying the physician of significant medications being missed due to the resident's schedule, then the physician may be unaware of any issues with the resident receiving medication that is important to the resident's wellbeing and recovery. This deficient practice likely contributed to multiple missed doses of heart medication and likely contributed to R #1's death. The findings are:</p> <p>A. Record review of R #1's hospital records, dated 06/04/24, indicated the following:</p> <ul style="list-style-type: none"> - Non-ST-elevation myocardial infarction (NSTEMI; a type of heart attack), - Multivessel coronary artery disease (MVCAD; involves two or more major arteries and occurs when too much plaque builds up within the arteries, making it harder for blood to circulate to supply oxygen and nutrients to the heart muscle) status post complex percutaneous coronary intervention (PCI; a minimally invasive non-surgical procedure used to treat narrowing of the coronary arteries using coronary stents), - Left anterior descending artery (LAD; the largest coronary artery that supplies blood to the front of the left side of the heart. Complete blockage of this artery is often fatal), - Drug-eluting stent (DES; a small mesh tube that is placed in the arteries to keep them open), - Percutaneous transluminal coronary angioplasty (PTCA; a minimally invasive procedure to open blocked coronary arteries) through minimally invasive surgery, - Clogged coronary arteries, - Left circumflex (an artery) with Impella (device that helps the heart pump blood when it is weak or failing). - Resident discharged to the facility [nursing home] on 06/17/24. <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0580</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>B. Record review of R #1's face sheet indicated she was admitted to the facility on [DATE], went out to the hospital on 06/23/24, and was readmitted to the facility on [DATE]. R #1 had the following diagnoses:</p> <ul style="list-style-type: none"> - Acute respiratory failure with hypoxia (when lungs cannot deliver enough oxygen or remove enough carbon dioxide from your blood), - Hypotension (low blood pressure), - Peripheral vascular disease (slow and progressive disorder of the blood vessels), - Stage 5 kidney disease (kidneys no longer have ability to function) with dependence on dialysis (blood filtered by machine), - Chronic systolic (congestive) heart failure (heart cannot pump blood well enough to give the body a normal supply), - Arteriosclerotic heart disease of coronary artery without angina pectoris (reduction of blood flow to the cardiac muscle due to build-up of plaque in the arteries of the heart), - Type II diabetes (a problem with how the body regulates sugar and insulin resistance). - This is not an all-inclusive list. <p>C. Record review of R #1's hospital discharge records, dated 07/01/24, indicated R #1 had been admitted to the hospital on 06/23/24 with what was described as an anxiety attack and was associated with shortness of breath and chest pain. R #1 reported that she has been having intermittent chest pain, worse with movement and deep breathing since her previous in-hospital cardiac arrest with chest compressions that occurred prior to her being admitted to this facility on 06/17/24. R #1 had last dialysis treatment yesterday [06/30/24] with no complications. admitted to the intensive care unit (ICU) for management of her hypoxic respiratory failure (respiratory failure is a condition where there is not enough oxygen or too much carbon dioxide in your body) and hypotension (low blood pressure). R #1 was discharged on [DATE] [back to the nursing home] with orders for Aspirin and Plavix.</p> <p>D. Record review of R #1's physician orders indicated the following:</p> <ul style="list-style-type: none"> - An order for dialysis on Tuesday, Thursday, and Saturday. Depart the facility at 7:00 am. Start date 07/02/24. - Aspirin, 81 milligrams, for heart health once per day. To be administered between 6:00 am and 9:00 am. Start date of 07/01/24. - Plavix, 75 mg for CAD (coronary artery disease). Once per day from 6:00 am to 9:00 am. Start date 07/01/24 <p>E. Record review of R #1's Medication Administration Record (MAR), dated 07/01/24 through 07/23/24, indicated staff did not administer the following medications to R #1:</p> <p>(continued on next page)</p>		

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<p>F 0580</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>- Aspirin, 81 mg, once per day on 07/02/24, 07/13/24, 07/16/24, 07/18/24 and 07/20/24. Further review showed the dates corresponded with R #1's dialysis days.</p> <p>- Plavix, 75 mg, once per day on 07/04/24, 07/09/24, 07/13/24, 07/16/24, 07/18/24, 07/20/24. Further review showed the dates corresponded with R #1's dialysis days.</p> <p>F. Record review of R #1's medical record progress notes and history and physical notes revealed staff did not notify the physician that R #1 has missed any medications.</p> <p>G. On 10/17/24 at 10:00 am, during an interview with the physician, he stated staff did not make him aware that R #1 missed medications. He stated he would have liked for staff to notify him, because he could have scheduled R #1's medication for a different time. He also stated Plavix medication should not be skipped or missed. He said if the resident missed doses of Plavix for new treatment, like a new stent that was put in recently, then that would be serious. The physician stated Plavix given with aspirin was designed to stop blood clots from forming after a new stent placement.</p> <p>H. On 10/17/24 at 2:26 pm, during an interview with Nurse #5, she stated R #1 did not get the medications on the dates she marked R #1 was not available. Nurse #5 also stated she did not notify the physician that R #1 missed the medications due to being at dialysis, and she did not ask the physician to schedule them at a different time.</p> <p>I. On 10/16/24 at 3:04 pm, during an interview with Family Member #2, she stated that when she arrived at the facility on 07/21/24 around noon, she found R #1 on her bed, and she was crying out God, please help me. Please help me. FM #2 walked in asked R #1 what was wrong, and R #1 appeared scared and was not aware that they [family] were in the room. R #1 answered FM #2 stating she did not feel well. FM #2 stated that the nurse came in and started discussing R #1's discharge [which was scheduled for that day]. When FM #2 asked N #5 why R #1 was acting the way she was, (weak and with altered mental status) she stated that R #1 was really anxious and this started after she signed the discharge paperwork. FM #2 stated that she was trying to sit R #1 up in bed and she just kept falling back over. She was too weak to sit up independently and was losing consciousness. FM #2 stated that she made the decision to have the ambulance called and have R #1 to sent to the hospital. She stated that the ambulance arrived quickly after 911 was called and she knew based upon how the paramedics were acting that something serious was wrong with R #1. FM #2 confirmed that R #1 passed away soon after arriving at the hospital and that the hospital physician reported that R #1 likely passed from cardiac arrest.</p> <p>Based on interview and record review, Immediate Jeopardy (IJ) was identified on 10/17/24 at 3:30 pm and presented to the Administrator and the Director of Nursing, in person.</p> <p>The facility took corrective action by providing an acceptable Plan of Removal (POR) on 10/18/24 at 4:00 pm. Implementation of the POR was verified onsite. On-going training for staff regarding notifying the provider of changes, such as a resident not receiving medications, and a full sweep of all residents was completed to identify any other resident who may not be getting medications as prescribed.</p> <p>Plan of Removal:</p> <p>Resident #1 has been discharged from the facility.</p> <p>(continued on next page)</p>		

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<p>F 0580</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Other Patients: No other patients are currently receiving dialysis, where medications could have been missed.</p> <p>All new patients who receive dialysis will have a medication review of appropriate times to be given around chair time.</p> <p>All patients' medication administration compliance report have been audited. MD was notified of findings and appropriate documentation was added.</p> <p>One patient was routinely out of the facility for an appointment, their entire administration record was audited, there were eight missed medication administrations. The provider was notified.</p> <p>Systemic Changes: Licensed nurses, on shift, have been educated regarding the policy. If a patient is out of the facility when a medication is due then the provider will be contacted, the facility will follow providers orders, and document notification in patients' progress notes. Education will be provided ongoing as nurses report to work.</p> <p>Surveillance: The Administrator will audit three times a week for four weeks to validate the completion of the training.</p> <p>The Director of Nursing will audit all patient's medication administration record for compliance three times a week for four weeks.</p> <p>Date of Compliance: 10/18/24</p>

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<p>F 0684</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35632</p> <p>Based on record review and interview, the facility failed to provide quality care to 1 (R #1) of 1 (R #1) resident when they failed to properly assess a resident with history of myocardial infarction (heart attack) after the resident began to experience anxiety for a couple hours before transferring the resident to the emergency room . If the facility fails to properly assess a resident with heart issues, then the resident may experience unidentified life-threatening conditions such as a heart attack. This deficient practice likely resulted in unnecessary distress and delay in treatment. The findings are:</p> <p>A. Record review of R #1's hospital records, dated 06/04/24, indicated the following:</p> <ul style="list-style-type: none"> - Non-ST-elevation myocardial infarction (NSTEMI; a type of heart attack), - Multivessel coronary artery disease (MVCAD; involves two or more major arteries and occurs when too much plaque builds up within the arteries, making it harder for blood to circulate to supply oxygen and nutrients to the heart muscle) status post complex percutaneous coronary intervention (PCI; a minimally invasive non-surgical procedure used to treat narrowing of the coronary arteries using coronary stents), - Left anterior descending artery (LAD; the largest coronary artery that supplies blood to the front of the left side of the heart. Complete blockage of this artery is often fatal), - Drug-eluting stent (DES; a small mesh tube that is placed in the arteries to keep them open), - Percutaneous transluminal coronary angioplasty (PTCA; a minimally invasive procedure to open blocked coronary arteries) through minimally invasive surgery, - Clogged coronary arteries, - Left circumflex (an artery) with Impella (device that helps the heart pump blood when it is weak or failing). - Resident discharged to the facility on [DATE]. <p>B. Record review of R #1's face sheet indicated she was admitted to the facility on [DATE], went out to the hospital on 06/23/24 for acute respiratory failure and was readmitted to the facility on [DATE]. She had the following diagnoses:</p> <ul style="list-style-type: none"> - Acute respiratory failure with hypoxia (when lungs cannot deliver enough oxygen or remove enough carbon dioxide from the blood), - Hypotension (low blood pressure), - Peripheral vascular disease (slow and progressive disorder of the blood vessels), <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<ul style="list-style-type: none"> - Stage 5 kidney disease (kidneys no longer have ability to function) with dependence on dialysis (blood filtered by machine), - Chronic systolic (congestive) heart failure (heart cannot pump blood well enough to give the body a normal supply), - Arteriosclerotic heart disease of coronary artery without angina pectoris (reduction of blood flow to the cardiac muscle due to build-up of plaque in the arteries of the heart), - Type II diabetes (a problem with how the body regulates sugar and insulin resistance). - This is not an all-inclusive list. <p>C. Record review of the R #1's Care Plan did not identify R #1's cardiac diagnosis or monitoring for signs and symptoms of a heart attack.</p> <p>D. Record review of R #1's nursing progress notes dated 07/21/24 dated indicated R #1 was going to be discharged from the facility on 07/21/24, and the resident's family was going to pick her up around noon. R #1 signed discharge paperwork and verbalized understanding of the medications that she was taking home. After R #1 signed paperwork and before the family arrived to pick up her up, the resident started to show symptoms of high anxiety, shaking and holding her breath, and exhibited signs of potential loss of consciousness. R #1 would be in the wheelchair and her arm would just hang off the side of the wheelchair. R #1 was alert and oriented times (x) four (A&O; a way of measuring the extent of a person's awareness. There are four levels - person, place, time, and situation - with A&Ox 4 meaning fully alert.) Staff took the resident's vital signs [body temperature, pulse rate, respiration rate (rate of breathing), oxygen saturation (amount of oxygen in the blood), and blood pressure], and they were in normal range. The resident's family arrived, and R #1 stated her chest felt heavy. The family packed up the resident's belongings and stated they would like for staff to call emergency medical services (EMS) to transport R #1 to the emergency room (ER). The nurse called and the R #1 left via stretcher at approximately 2:12 pm. Nurse #3 asked R #1 if she wanted to go out to the hospital, and R #1 stated she did not want to go.</p> <p>E. On 10/16/24 at 11:20 am, during an interview with the Director of Nursing (DON), she read the progress note dated 07/21/24, and stated it appeared R #1 had normal vital signs. She stated R #1 was answering questions. The DON stated R #1 had some behaviors and was anxious, but she did not take any medications for anxiety.</p> <p>F. On 10/16/24 at 12:15 pm, during an interview with R #1's Family Member (FM) #1, she stated she spoke to R #1 the morning of 07/21/24 via telephone since R #1 was scheduled to discharge home and she was fine. She stated R #1 seemed to be happy to go home. She said the last time she spoke with R #1 was around 10:24 am. FM #1 stated she arrived at the facility around noon time and found R #1 lying halfway down in her bed, trying to catch her breath. FM #1 stated R #1 woke up when they arrived, and she seemed scared. FM #1 stated the resident said, Help me, help me. FM #1 stated she went to find the nurse, and the nurse told her R #1 was having anxiety about going home. FM #1 stated she did not feel it was anxiety, because it seemed like R #1 was losing consciousness. She said she asked staff to take R #1's vital signs, and they did. FM #1 stated she did not know what R #1's vital signs were, but she knew they were low. FM #1 stated staff called an ambulance to take R #1 to the hospital.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>G. On 10/16/24 at 3:04 pm, during an interview with Family Member (FM) #2, she stated R #1 was in a good mood, happy and seemed totally fine on the phone the morning of 07/21/24. FM #2 stated they arrived to the facility a little after noon on 07/21/24. She stated she walked into R #1's room, and she was taken back. FM #2 stated R #1's night gown was pulled up and her brief was visible. She said R #1 lay on the bed and cried out for help. FM #2 stated R #1 said, God, please help me. FM #2 said she asked R #1 what was wrong, and R #1 responded she did not know. She stated R #1 said she just did not feel good. FM #2 stated Nurse #3 came into the room talked to the family about discharge. FM #2 stated Nurse #3 reported R #1 was like that [anxious] for a couple hours, and R #1 was anxious after she signed the paperwork. FM #2 said she tried a few times to help R #1 sit up in bed, but R #1 would just fall back again. FM #2 stated R #1 could not hold herself up and complained of someone sitting on her chest. She said they requested staff to take R #1's vital signs, and staff did. FM #2 stated they did not know what R #1's vitals signs were. FM #2 said Nurse #3 told the family if R #1 did not discharge from the facility, then R #1 would need to be sent out to the hospital. FM #2 stated she made the decision to send R #1 out to the hospital. She stated that she could not believe Nurse #3 kept telling her that it was anxiety.</p> <p>H. On 10/16/24 at 2:35 pm, during an interview with Nurse #3, she stated R #1 had anxiety over going home on the morning of 07/21/24. She stated she was with R #1 a lot that morning, because R #1 was going to discharge from the facility that day. She stated R #1 signed the discharge paperwork and then she started to act differently. Nurse #3 stated R #1 would close her eyes and go limp in her wheelchair. Nurse #3 stated she would touch R #1 and ask the resident what was wrong, and R #1 would answer her. Nurse #3 stated she did a sternal rub (a painful stimulus to assess a resident's responsiveness) on R #1, but she then clarified it was more like touching the resident's chest to see if R #1 was alright. Nurse #3 stated she felt like R #1 was nervous about going home and was having a lot of anxiety. She stated R #1 never lost consciousness and always answered questions when asked. She said she addressed R #1's anxiety by distracting her with conversation. Nurse #3 stated she did not see R #1 fall over in bed after the family sat her up. She stated she did not recall if R #1 said she could not breathe or if R #1 expressed that her chest was heavy. Nurse #3 said R #1 never had abnormal vitals she did not think R #1 was having a change in condition since the resident's vitals were never abnormal. Nurse #3 confirmed R #1 was not provided anxiety medication on 07/21/24.</p>		

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<p>F 0760</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Ensure that residents are free from significant medication errors.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35632</p> <p>Based on record review and interview, the facility failed to administer significant medication of plavix and aspirin (plavix and aspirin a medication used to prevent heart attacks and strokes in persons with heart disease, recent stroke, or blood circulation disease. It is also used with aspirin to treat new or worsening chest pain, to keep blood vessels open, and to prevent blood clots after certain procedures, such as cardiac stent.) ordered by the physician for 1 (R #1) of 3 (R #1, #2 and #3) residents reviewed for medications. This deficient practice has the potential to jeopardize the resident's health and safety could likely have contributed to R #1's death. The findings are.</p> <p>A. Record review of R #1's hospital records, dated 06/04/24, indicated the following:</p> <ul style="list-style-type: none"> - Non-ST-elevation myocardial infarction (NSTEMI; a type of heart attack), - Multivessel coronary artery disease (MVCAD; involves two or more major arteries and occurs when too much plaque builds up within the arteries, making it harder for blood to circulate to supply oxygen and nutrients to the heart muscle) status post complex percutaneous coronary intervention (PCI; a minimally invasive non-surgical procedure used to treat narrowing of the coronary arteries using coronary stents), - Left anterior descending artery (LAD; the largest coronary artery that supplies blood to the front of the left side of the heart. Complete blockage of this artery is often fatal), - Drug-eluting stent (DES; a small mesh tube that is placed in the arteries to keep them open), - Percutaneous transluminal coronary angioplasty (PTCA; a minimally invasive procedure to open blocked coronary arteries) through minimally invasive surgery, - Clogged coronary arteries, - Left circumflex (an artery) with Impella (device that helps the heart pump blood when it is weak or failing). - Resident discharged to the facility [nursing home] on 06/17/24. <p>B. Record review of R #1's face sheet indicated she was admitted to the facility on [DATE], went out to the hospital on 06/23/24, and was readmitted to the facility on [DATE]. She had the following diagnoses:</p> <ul style="list-style-type: none"> - Acute respiratory failure with hypoxia (when lungs cannot deliver enough oxygen or remove enough carbon dioxide from the blood), - Hypotension (low blood pressure), - Peripheral vascular disease (slow and progressive disorder of the blood vessels), <p>(continued on next page)</p>		

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<p>F 0760</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>F. On 10/16/24 at 11:20 am, during an interview with the Director of Nursing (DON), she stated if a resident was out of the facility when their medications were scheduled for administration, then staff should administer their medications when the resident returned to the facility. The DON stated the delayed administration depended on the medications the resident missed. She stated if the resident was due for another dose of the medications, then staff should skip the missed dose and give the next dose. The DON stated if the medication was given once per day, then staff should administer the medication when the resident returned to the facility. The DON acknowledged that missing a medication that is scheduled for one time per day should not happen. She stated that R #1's time to administer medications was when R#1 was at dialysis and that the medication should have been changed to another time [after dialysis] by the physician.</p> <p>G. On 10/17/24 at 9:40 am, during an interview with N #5, she stated that on R #1's dialysis days she would be out of the facility before she even started working at 6:00 am. That is the reason that she did not get her medications on those days. She confirmed that she did not notify the physician of the medications that R #1 missed or request from the physician to have the administration time changed.</p> <p>H. On 10/17/24 at 10:00 am, during an interview with the facility's Physician, he stated Plavix medication should not be skipped or missed. He said if the resident missed doses of Plavix for new treatment, like a new stent that was put in recently, then that would be serious. The physician stated Plavix given with aspirin was designed to stop blood clots from forming after a new stent placement.</p> <p>I. On 10/16/24 at 3:04 pm, during an interview with Family member #2, she stated that when she arrived at the facility on 07/21/24 around noon, she found R #1 on her bed, and she was crying out God, please help me. Please help me. FM #2 walked in asked R #1 what was wrong, and R #1 appeared scared and wasn't aware that they [family] were in the room. R #1 answered FM #2 stating she did not feel well. FM #2 stated that the nurse came in and started discussing R #1's discharge [which was scheduled for that day]. When FM #2 asked N #5 why R #1 was acting the way she was, (weak and with altered mental status) she stated that R #1 was really anxious and this started after she signed the discharge paperwork. FM #2 stated that she was trying to sit R #1 up in bed and she just kept falling back over. She was too weak to sit up independently and was losing consciousness. FM #2 stated that she made the decision to have the ambulance called and have R #1 to sent to the hospital. She stated that the ambulance arrived quickly after 911 was called and she knew based upon how the paramedics were acting that something serious was wrong with R #1. FM #2 confirmed that R #1 passed away soon after arriving at the hospital and that the hospital physician reported that R #1 likely passed from cardiac arrest.</p> <p>Based on interview and record review, Immediate Jeopardy (IJ) was identified on 10/17/24 at 3:30 pm and presented to the Administrator and the Director of Nursing, in person.</p> <p>The facility took corrective action by providing an acceptable Plan of Removal (POR) on 10/18/24 at 4:00 pm. Implementation of the POR was verified onsite. On-going training for staff regarding notifying the provider of changes, such as a resident not receiving medications, and a full sweep of all residents was completed to identify any other resident who may not be getting medications as prescribed.</p> <p>Plan of Removal:</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 325119	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/21/2024
NAME OF PROVIDER OR SUPPLIER Advanced Health Care of Albuquerque		STREET ADDRESS, CITY, STATE, ZIP CODE 2701 Richmond Drive NE Albuquerque, NM 87107	

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<p>F 0760</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Resident #1 has been discharged from the facility.</p> <p>Other Patients: No other patients are currently receiving dialysis, where medications could have been missed.</p> <p>All new patients who receive dialysis will have a medication review of appropriate times to be given around chair time.</p> <p>All patients' medication administration compliance report have been audited. MD was notified of findings and appropriate documentation was added.</p> <p>One patient was routinely out of the facility for an appointment, their entire administration record was audited, there were eight missed medication administrations. The provider was notified.</p> <p>Systemic Changes: Licensed nurses, on shift, have been educated regarding the policy. If a patient is out of the facility when a medication is due then the provider will be contacted, the facility will follow providers orders, and document notification in patients' progress notes. Education will be provided ongoing as nurses report to work.</p> <p>Surveillance: The Administrator will audit three times a week for four weeks to validate the completion of the training.</p> <p>The Director of Nursing will audit all patient's medication administration record for compliance three times a week for four weeks.</p> <p>Date of Compliance: 10/18/24</p>