STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	325036	A. Building B. Wing	01/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Las Palomas Center	8100 Palomas Avenue NE Albuquerque, NM 87109

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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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. 33768 PAST NON-COMPLIANCE Based on record review and interview, the facility failed to ensure residents were free from misappropriation of property for 2 (R #2 and #3) of 2 (R #2 and #3) residents reviewed when a nurse removed the residents' oxycodone (narcotic pain medication) from the medication card for her own personal use. This deficient practice could likely result in a delay or residents not getting the care and treatment needed. The findings are: A. Record review of the facility's self-report for medication diversion, dated 10/24/24, revealed a nurse removed discharged meds [medications] from the med cart and stated she would give them to the DON [Director of Nursing]. B. On 01/02/25 at 2:01 pm during interview with the Administrator and DON, they stated a nurse contacted the former DON regarding Registered Nurse (RN) / Wound Care Nurse #1 taking medications out of the medication cart. The Administrator and DON stated the nurse reported RN #1 told him the medications were discontinued, and she was going to give them to the DON. The Administrator and DON stated the nurse asked the DON later if RN #1 brought the medications to her (DON), but the DON said RN #1 did not bring them. The Administrator and DON stated an investigation was started immediately. The Administrator and DON stated RN #1 was still in the building when she was confronted about the missing medications. The Administrator and DON stated RN #1 eventually admitted that she took the medications for R #2 and R #3 and later returned the medication cards with 13 oxycodone pills missing from medication cards (combined.) The Administrator and DON stated RN #1 did not provide any resident care during that time, and the entire incident occurred within approximately 40 minutes. The ADMIN and DON stated RN #1 was terminated, law enforcement was contacted, and a referral was made to the Board of Nursing for RN #1. The Administrator and DON confirmed staff assessed both residents, and there were not any adverse reactions or unrelieved pain. The Administrator and DON stated staff audited all four medication carts and confirmed there was not any other missing medication. C. Record review of the facility's follow-up investigation report, dated 12/02/24, substantiated (found evidence of) drug diversion and identified the following corrective actions: 1. The nurses within the facility received chain of custody education to ensure other nurses should not be removing medication from the medication carts. (continued on next page)

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

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Reviewed all medications carts, compared Medication Administration Records (MARs) for all controlled substances, and did not find any other discrepancies. D. Record review of the Employee Training Sign-In Sheet, dated 10/23/24, revealed 18 nurses received training that included Nursing staff must keep their medications carts locked every time they step away. Do not lend your keys to anyone. Only UM (Unit Managers) and [Name of DON] are allowed to remove narcotics for destruction. E. Record review of R #2's Medication Administration Record, dated October 2024, revealed the following: 1. An order to receive oxycodone 10 milligrams (mg) every six hours as needed for pain. 2. Dated 10/23/24, staff administered two doses of oxycodone to R #2 and documented the medication was effective. F. On 01/02/25 at 11:31 am during interview and observation with R #2, she confirmed she received pain medication, and it was effective. R #2 did not have any concerns related to her pain medication and did not show any visible signs of pain or distress during the interview. G. Record review of R #3's Narcotic Sheet, dated October 2024, revealed an order for oxycodone 10 mg every six hours for pain. H. On 01/02/25 at 11:35 am, during an attempt to interview, R #3 did not respond to questions. Observations revealed the resident did not have any visible signs of distress or pain during the interview. I. On 01/02/25 at 12:05 pm during observation of a random narcotic count with RN #2 of the medication cart on South unit, medication discrepancies were not identified.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 33768 Based on record review, observation, and interview, the facility failed to provide the required assistance for 1 (R #1) of 1 (R #1) resident reviewed during a random observation of meal time. This deficient practice could likely result in R #1 being at risk for aspiration (accidental inhale food or liquid into the lungs) and choking. The findings are: A. On 12/02/25 at 9:50 am during observation. R #1 ate his breakfast in bed. Staff were not present. B. On 12/02/25 at 10:04 am during an interview with Licensed Practical Nurse (LPN) #1, he stated R #1 was able to feed himself; however, staff check on him to monitor his swallowing. LPN #1 stated R #1 did not require supervision while he ate. C. Record review of R #1's Care Plan, initiated 11/25/24, revealed R #1 was a nutritional risk due to need for thickened liquids and dependence on staff for feeding. Interventions included the following: 1. Feeding assist with all means in upright position. 2. Monitor for signs/symptoms of aspiration. D. Record review of R #1's Nutritional Assessment revealed the following: 1. Dated 08/05/24, August weight was 141 pounds (lbs), which was a 33.4 lb weight loss in 60 days. Will request reweigh. R #1 needed assistance with feeding for all meals. The nurse reported the resident's by mouth intake was good; however, the resident was coughing at breakfast. Will notify Speech and Language Pathologist (SLP.) Liquid protein not warranted. May need calories supplement if weight re-check indicates a weight loss. E. Record review of R #1's Order Summary revealed: 1. Dated 08/05/24, a dysphagia order per SLP. Direct Assistance and supervision due to high aspiration risk. Sit upright for all by mouth intake. F. On 01/02/25 at 12:44 pm during an interview with the Registered Dietician (RD), she stated R #1 had a pressure wound on his sacrum, and she recently increased his meal portions. The RD stated, My understanding is he cannot feed himself. G. On 01/02/25 at 1:20 pm during an interview with the Speech Therapist (ST), she confirmed she had evaluated R #1 on 08/05/24, and R #1 needed direct assistance from care givers for meals. The ST stated that meant One-on-one. Someone feeding him. The ST stated the order was based on the resident's ability to feed himself and his aspiration risk. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	H. On 01/02/25 at 1:31 pm during an observation, R #1 sat in his bed and ate his lunch. Staff were not present. R #1's meal ticket included a gelatin supplement, but a supplement was not on his meal tray. I. On 01/02/25 from 1:31 pm through 1:50 pm, during an observation, R #1 ate his lunch in his room. Staff did not check on R #1 during this time. J. On 01/02/25 at 1:51 pm during an observation and interview, R #1 drank a liquid and coughed. CNA #1 walked into R #1's room to check on him. CNA #1 stated R #1 fed himself, and he liked to keep his meal trays for a long time. CNA #1 stated the nurses tell them (CNAs) what kind of assistance the residents require when eating. CNA #1 stated that lately R #1 did not eat as much, but sometimes he received a healthshake for snack. CNA #1 stated she had not seen a Gelatein on the resident's meal tray before.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough food/fluids to maintain a resident's health. 33768 Based on observation, record review, and interview, the facility failed to ensure 1 (R #1) of 1 (R #1) resident reviewed maintained acceptable parameters of nutritional status when they did not: 1. Monitor R #1's meal intakes, 2. Ensure R #1 received his ordered nutritional supplement. This deficient practice could likely result in resident weight loss and adverse effects. The findings are: A. On 12/02/25 at 9:50 am during observation, R #1 ate breakfast in bed, and staff were not present. R #1 struggled to reach his tray, put food on the utensil, and move his beverage to his mouth. B. On 12/02/25 at 10:04 am during interview with Licensed Practical Nurse (LPN) #1, he stated R #1 was able to feed himself; however, staff check on the resident to monitor his swallowing. LPN #1 stated R #1 did not require supervision while he ate. C. Record review of R #1's Care Plan, initiated 11/25/24, revealed R #1 was at nutritional risk due to the need for thickened liquids and dependence on staff for feeding. Interventions included the following: 1. Encourage resident to chew and swallow each bite. 2. Monitor for changes in nutritional status (changes in intake, ability to feed self, unplanned weight loss/gain, abnormal labs) and report to nutrition/physician as indicated. 3. Monitor intake at all meals, offer alternative choices as needed, alert dietician and physician to any decline in intake. 4. Feeding assist with all means in upright position. 5. Monitor for signs/symptoms of aspiration. D. Record review of R #1's Nutritional Assessment revealed the following: 1. Dated 08/05/24, August weight was 141 pounds (lbs), which was a 33.4 lb weight loss in 60 days. Will request reweigh. R #1 needed assistance with feeding for all meals. The nurse reported the resident's by mouth intake was good; however, resident was coughing at breakfast. Will notify Speech and Language Pathologist (SLP.) Liquid protein not warranted. May need calories supplement if weight re-check indicates a weight loss. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. Dated 11/06/24, the resident's weight was decreasing over the past few months. Eleven pound loss in one month (7.1% decrease), 18 lb loss in three months (11.1% decrease). No recorded meals at this time. Per nursing staff, resident consumed 100% of meals. Nurse felt that weight change may be inaccurate. Will reweigh to verify weight changes. E. Record review R #1 weights revealed staff documented the following: 1. On 06/03/24, 174.5 lbs, 2. On 08/06/24, 162.9 lbs, 3. On 10/02/24, 156.3 lbs, 4. On 11/03/24, 144.8 lbs, 5. On 12/04/24, 144.9 lbs. F. Record review of R #1's Order Summary revealed an order, dated 12/05/24, for Gelatein Plus (high protein gelatin) from central supply, two times a day with lunch and dinner, for weight loss. G. Record review of R #1's Medication Administration Record and Treatment Administration Record, dated December 2024 and January 2025, revealed the records did not contain the order for Gelatein Plus. H. On 01/02/25 at 12:44 pm during an interview with the Registered Dietician (RD), she stated R #1 had a pressure wound on his sacrum, and she recently increased his meal portions. She stated staff told her R #1 ate well, but she did not see any documentation of the resident's meal intake percentages. The RD confirmed she relied on staff feedback regarding how much the resident ate. The RD stated, My understanding is he cannot feed himself. The RD stated she ordered R #1 to receive Gelatein Plus honey thick twice a day at lunch and in the evening. The RD stated she was not sure if the resident received it. The RD stated other interventions for the resident could be for staff to weigh the resident more often, but she did not order that. I. On 01/02/25 at 1:09 pm during interview with the Minimum Data Set (MDS) Coordinator, she reviewed R #1 medical record and stated staff did not document R #1's meal intake percentages. J. On 01/02/25 from 1:31 pm through 1:50 pm, during an observation, R #1 ate his lunch in his room. Staff did not check on R #1 during this time. K. On 01/02/25 at 1:51 pm during an observation and interview, R #1 drank a liquid and coughed. CNA #1 walked into R #1's room to check on him. CNA #1 stated R #1 fed himself, and he liked to keep his meal trays for a long time. CNA #1 stated that lately R #1 did not eat as much, but sometimes he received a health shake for snack. CNA #1 stated she had not seen a Gelatein on the resident's meal tray before. L. On 01/02/25 at 1:54 pm during an interview with LPN #1, he confirmed that he has not seen Gelatein on R #1's meal tray before. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	M. On 01/02/25 at 2:44 pm during an interview with the Dietary Manager (DM), he stated the Dietary staff did not provide the Gelatein for the residents, but it was available to the nurses in Central Supply (facility storage). N. On 01/02/25 at 2:47 pm during an interview with LPN #1, he stated he asked another nurse about Gelatein, and they said it was in Central Supply. LPN #1 stated he did not know R #1 was suppose to get Gelatein, because it was not on R #1's MAR.

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. 33768 Based on observation and interview, the facility failed to ensure call light were in working order for 1 (R #1) of 1 (R #1) resident reviewed during random observation. If the facility is not ensuring a working call light system, then residents and staff are unable to request immediate assistance when needed. The findings are: A. On 01/02/25 at 9:50 am during observation, R #1 sat upright in bed and ate breakfast. R #1 mouthed the word help. Surveyor pressed the call light pinned to the side of R #1's bed. B. On 01/02/25 at 9:51 am during observation, the call light was pressed again, but there was not an audible sound or a light outside R #1's room above the door way. C. On 01/02/25 at 10:04 am during interview with the Licensed Practical Nurse (LPN) #1, he stated R #1 was unable to use his call light. He stated they considered getting the resident a pad (call light trigger), but did not do it yet. LPN #1 confirmed that he was unaware the call light for R #1 was not functional.