STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 325036	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/03/2025
NAME OF PROVIDER OR SUPPLIER Las Palomas Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0577 Level of Harm - Potential for minimal harm Residents Affected - Many	Allow residents to easily view the nursing home's survey results and communicate with advocate agencies. 33768 Based on observation and interview, the facility failed to have the most recent survey results and any plan of corrections available in a place that was readily accessible to residents, family members, legal representatives and visitors. This deficient practice likely affects all resident identified on the census list provided by the Administrator on 02/14/25. If residents are unable to locate the latest survey results conducted by State Surveyors then residents, representatives, and visitors are unable to know how the facility is doing and make placement decisions accordingly. The findings are: A. On 02/14/25 at 10:01 am during observation of the facility lobby and interview with the Administrator, the survey report binder was not observed. When asked where the survey report binder is kept, the Administrator stated that the binder was in his office so that he would be able to update it. The Administrator pulled a binder from his bookshelf that was labeled Survey 2021-2023. The Administrator confirmed that the survey report binder was not updated with the most recent surveys including all reports after 2023 and was not available to residents and visitors to review. B. Record review of the State Agency Tracking database revealed that there were (7) survey investigations conducted between 2024 through January 2025 that resulted in a survey report.

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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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41988 Based on observation, record review, and interview, the facility failed to notify the resident's physician for 2 (R #2 and #6) of 2 (R #2 and #6) residents reviewed when: 1. R #2 began having difficulty feeding herself with low meal intake percentages 2. R #6 developed a sacrum wound These deficient practices likely resulted in R #2 not getting the assistance she needed resulting in a decrease in meal intake and a delay in treatment and deterioration in R #6's wound likely resulting in the wound becoming septic. The findings are: Findings for R #2 A. Record review of R #2's face sheet revealed R #2 was admitted into the facility on [DATE]. B. Record review of R #2's care plan dated 01/27/25 revealed the following: 1. R #2 exhibits impaired swallowing related to dementia; Provide assistance during meals and provide supervision during meals. 2. R #2 is a nutritional risk related to skin breakdown; Weigh per policy and as needed, and alert dietitian and physician to any significant weight loss or gain. C. Record review of the facility meal consumption percentage (%) tracking form dated 02/03/25 through 02/20/25 (breakfast), revealed the following: - 02/03/25: R #2 ate 25% of her breakfast, 50% of her lunch, and 25% of her dinner. - 02/04/25: R #2 ate 50% of her breakfast, 75% of her lunch, and 25% of her dinner. - 02/05/24: R #2's meal intake was not recorded. - 02/06/25: R #2 ate 50% of her breakfast, 50% of her lunch, and 75% of her dinner. - 02/07/25: R #2 ate 50% of her breakfast, 25% of her lunch, and 75% of her dinner. - 02/08/25: R #2 ate 100% of her breakfast, 25% of her lunch, and 25% of her dinner. - 02/09/25: R #2 ate 50% of her breakfast, 25% of her lunch, and 75% of her dinner. - 02/10/25: R #2 ate 50% of her breakfast, 50% of her lunch, and 75% of her dinner. - 02/11/25: R #2 ate 50% of her breakfast, 50% of her lunch, and 75% of her dinner. (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	- 02/12/25: R #2 ate 50% of her breakfast, 25% of her lunch, and 50% of her dinner. - 02/13/25: R #2 ate 25% of her breakfast, 25% of her lunch, and 0% of her dinner. - 02/14/25: R #2 ate 25% of her breakfast, 25% of her lunch, and 25% of her dinner. - 02/15/25: R #2 ate 50% of her breakfast, 25% of her lunch, and 100% of her dinner. - 02/16/25: R #2 ate 75% of her breakfast, 25% of her lunch, and 25% of her dinner. - 02/17/25: R #2 ate 25% of her breakfast, 50% of her lunch, and 25% of her dinner. - 02/18/25: R #2 ate 50% of her breakfast, 50% of her lunch, and 50% of her dinner. - 02/19/25: R #2 ate 100% of her breakfast, lunch was not recorded, and 100% of her dinner. - 02/20/25: R #2 ate 75% of her breakfast. R #2's meal consumption percentage was not recorded prior to 02/03/25. D. Record review of R #2's Electronic Health Record (EHR) banner reviewed on 02/19/25 revealed Set-up for all meals and no feeding assistance required. E. On 02/19/25 at 2:08 pm during an interview with R #2's Power of Attorney (POA; authority to act for another person in specified or all legal or financial matters), she stated that on multiple occasions, R #2's meal tray was left in front of her untouched by R #2. R #2's POA also stated that R #2 requires assistance with feeding, but the facility is not helping with that. F. On 02/19/25 at 3:41 pm during an interview with Licensed Practical Nurse (LPN) #2, she stated that R #2 is a set-up help only for meals. LPN #2 confirmed that she was not aware of R #2 experiencing difficulty feeding herself. G. On 02/19/25 at 4:37 pm during an interview with LPN #3, she stated that the majority of the time the facility CNAs (Certified Nursing Assistant's) will only set up R #2's meal and they will not assist her with feeding. LPN #3 also stated that R #2 usually needs help with feeding, and will require supervision when eating as well. LPN #3 confirmed she would help R #2 with feeding as often as she could, but R #2 required feeding assistance and meal supervision on a consistent basis. H. On 02/19/25 at 5:14 pm during a dinner observation, R #2 was observed lying in bed and then being woken up by CNA #3 for dinner. CNA #3 moved R #2's bed up so R #2 could eat. I. On 02/19/25 at 5:15 pm during an interview with CNA #3, she stated that R #2 was a set-up assist only and the CNAs will check on R #2 as often as they can during the meal service. CNA #3 was observed leaving R #2's room shortly after the interview to continue to pass out resident meal trays in the unit. (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	J. On 02/19/25 at 5:19 pm during a dinner observation, R #2 was observed sitting upright in her bed attempting to eat without staff presence. R #2's spoon was in the middle of her plate and she was trying to eat her orange dessert by licking the side of the dessert dish. R #2 was not successful in doing so. K. On 02/19/25 at 5:28 pm during a dinner observation, CNA #3 is observed returning to R #2's room to assist R #2 with her meal. L. On 02/19/25 at 5:30 pm during an interview with CNA #3, she stated that R #2 was just playing with her food and not eating it, which R #2 does a lot. CNA #3 also stated that R #2 is more dependant on staff assisting her with her meals because she can't feed herself that well anymore. M. On 02/20/25 at 11:49 am during an interview with the Physician's Assistant (PA), she stated that she was not made aware of R #2's inability to feed herself and she would expect the facility nursing staff to notify the facility providers, including the DON of this, especially if there is weight loss. N. On 02/20/25 at 12:38 pm during an interview with the RD, she stated that she was unaware of R #2's low meal consumption percentage and she was also unaware of R #2's self feeding limitations. The RD stated that had not reviewed the facility meal consumption percentage tracking form, and would find out about dietary issues from the facility nursing staff. The RD confirmed that she should have been made aware of R #2's inability to consistently feed herself, and R #2 should be reassessed by the speech therapist to get a better understanding of R #2's feeding limitations. O. On 02/20/25 at 1:04 pm during an interview with the Administrator (ADM), he stated that he would expect the RD to be monitoring the facility meal consumption percentage tracking form. The ADM also stated that the CNAs should be notifying the nursing staff, who should be notifying facility providers of a residents decline in self feeding so it can be addressed in the morning clinical meeting. P. On 02/20/25 at 2:41 pm during an interview with Registered Nurse (RN) #1, she stated that R #2 can raise her hand and wipe her mouth, but she does not believe that R #2 could feed herself successfully. RN #1 stated that she does not think the RD has been made aware of this, but she was unsure. Q. On 02/20/25 at 3:07 pm during an interview with the DON, she stated that if CNAs notice R #2 is struggling to feed herself, then they need to notify nursing staff who should then notify her, the RD, and any provider that needs to be informed of that. 38450 Findings related to R #6 Cross reference to F684. R. Record review of R #6's Wound Evaluation, dated 11/28/24, revealed the following: - Burn, third degree. - Staged by in-house nursing. (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	- Located on sacrum (a large flat bone in the lower part of the spine.) - Minutes old and acquired in-house (at the facility.) - Measurements: length 6.64 centimeters (cm), width 4.2 cm, depth 0.2 cm, area 15.95 cm^2. - Wound bed: Epithelial tissue (a thin, continuous layer of cells) present, granulation tissue (new connective tissue and blood vessels, a sign of wound healing) present. - Moderate serosanguineous (clear or light pink, thin, watery fluid) exudate (body fluid discharged by the body in response to tissue damage and wound healing.) - Edges attached, surrounding tissue erythema (redness.) - Temperature was hot, localized. - Resident reported pain at a 7 out of 10 during dressing. - Treatment: Generic wound cleanser, composite dressing, and Xeroform bordered gauze. - Notes: Resident's skin was hot to touch with a heating pad under her. The resident's skin was thin and fragile. Removed the heating pad. - Education: The resident was educated about the risk factors involved in using a heating pad. Resident was strongly advised to discontinue use of the heating pad and to shift weight in bed frequently. - Notification: None documented. - Digitally signed by the facility's Skin Health Team Lead (SHTL) on 11/29/24 at 12:33 pm. S. Record review of R #6's medical record revealed the following the record did not contain documentation staff notified the resident's doctor of the third degree burn on the resident's sacrum. T. Record review of R #6's Progress Note, dated 12/02/25, revealed the following: - Visit type was acute follow-up. - Chief complaint and nature of the presenting problem: Follow-up of admitting medical diagnoses, including depression. - Resident was a fairly inconsistent historian but at time of encounter denied complaint or concern. - Nursing staff denied new or worsening behaviors, recent fall or injury, unstable vital signs, or other complaint or concern. - The record did not mention the resident's sacrum burn or treatment for the burn. (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	- Digitally signed and dated by the Nurse Practitioner on 12/03/24 at 4:55 pm. U. Record review of R #6's Wound Evaluation, dated 12/04/24, revealed the following: - Burn, third degree. - Staged by in-house nursing. - Located on sacrum. - Six days old and acquired in-house. - Measurements: length 6.24 cm, width 3.9 cm, depth 0.2 cm, area 18.24 cm^2. - Wound bed 70 percent (%) epithelial, 70% granulation, 20% slough (yellow stringy tissue adhered to wound bed.) - Evidence of infection: increased drainage, increased pain. - Bleeding. - Moderate serosanguineous exudate with faint odor after cleaning. - Edges attached, surrounding tissue erythema. - Resident reported pain at a 7 out of 10 during dressing. - Dressing appeared saturated. - Treatment: Vashe (wound cleanser), Medihoney (wound and burn gel), foam, incontinence management. - Healable. - Stable. - Notification: None documented. - Digitally signed and dated by the facility's SHTL on 11/4/25 at 1:05 pm. V. Record review of R #6's Progress Note, dated 12/06/25, revealed the following: - Visit type: Discharge. - Chief complaint and nature of the presenting problem: Discharge summary and plan. (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	- The resident was initially to be seen today for discharge summary and plan. The NP was contacted by the wound care nurse and notified the resident had a burn to her back. The burn reported had an odor and greenish discharge. The resident was asymptomatic without indication of sepsis or systemic infection. Patient lay in bed, and did not appear to be in acute distress. Resident was a poor historian secondary to dementia, and the NP was unable to reposition the resident at the time of the encounter in order to examine the resident's back. Order to apply silver sulfadiazine cream (antibiotic cream for serious skin infections and burns) 1% placed with wound care nurse. No other concerns noted at time of encounter. - Discharge home. - Discharge condition stable. - Diagnosis: Superficial burn. - Plan for superficial burn: No signs of systemic infection. Continue silver sulfadiazine 1% cream twice daily. Follow-up with primary care physician for further management. - Digitally signed by the NP on 12/9/25 at 8:24 pm. (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	W. On 03/05/25 at 2:17 pm, during an interview, R #6's daughter stated her mother was admitted to the facility on [DATE] for rehabilitation to get her strength up. She stated she was not aware of any of her mother's wounds when her mother arrived at the facility. The daughter stated there was a care plan meeting on 11/18/24, and the staff told her about her mother's pressure ulcers. The daughter stated she visited her mother almost every day, sometimes in the morning and sometimes in the afternoon. She stated she visited her mother early in the day on 12/04/24, and the wound nurse stated she did not like the way her mother's sacrum wound looked because it was turning green. The daughter stated the wound nurse took a picture and sent it to her and told her she would send the picture to the doctor. The daughter stated it had been four days since she saw her mother and it looked a lot worse than the last time she saw the wound. She stated she asked the wound nurse what she was looking at in the picture, and the wound nurse told her it was slough, which could lead to infection. The daughter stated she spoke to a Certified Nursing Assistant (CNA) on 12/07/25, and the CNA stated her mother was not feeling well and did not go to dialysis. The daughter stated the CNA reported she applied a salve to her mother's wound twice a day, and her mother's wound had a smell to it. The daughter stated over the next couple days her mother did not look well. She stated by the day she discharged (12/09/24) her mother looked horrible and was sweating. She stated the CNAs did not know why her mom was sweating. The daughter stated they tried to move her mother into a chair, but her mother begged to get back into bed. The daughter stated her mother was supposed to discharge from the nursing home at noon on 12/09/24, but she was not ready on time. She stated her mother was in an unusual amount of pain when the two CNAs transferred her into a wheelchair, and her mother was confused and agitated. She stated her mother was not mentally herself, and her back was covered with sweat. The daughter stated the facility did not have transportation to take her mother to the Assisted Living Facility (ALF) which was right down the street from the facility. She stated two CNAs from the facility were not able to transfer her mother into her car, because her mother was in a lot of pain. She stated her mother was propelled in a wheelchair up the street to the ALF. She stated when her mother got to the ALF, staff put her right to bed, and her mother calmed down. The daughter stated her mother was in too much pain to sit up. The daughter stated her mother was scheduled for dialysis on 12/10/24, but the dialysis center sent her mother to the emergency room , because her heart rate was very low. The daughter stated her mother was admitted to the hospital with a diagnosis of septic shock. They told her that her mother had a racing heart rhythm, low blood pressure, and was incoherent. The daughter stated her mother was too weak for a full session of dialysis, and she passed away in the hospital eight days later. X. On 03/06/25 at 11:26 am, during an interview, the Physician Assistant (PA) stated she was at the facility Monday through Friday, every week; and she was responsible for seeing each resident, evaluating new conditions, diagnosing, prescribing treatments, and following-up with the residents. She stated it was expected for staff to notify her if a resident had a change of condition, medication issue, or a physical condition which required her attention. She stated staff could notify her while she was at the facility or call her at the on-call number if she was not at the facility. The PA reviewed R #6's initial wound documentation, dated 11/28/24, and stated she would expect staff to notify her of a wound like that. The PA stated she would have prescribed a barrier cream for the wound. (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Y. On 03/07/25 at 11:38 am, during an interview, the Medical Director (MD) stated she has been the facility's MD for several years. She stated she was not familiar with R #6, but she reviewed the resident's discharge summary. The MD reviewed R #6's initial wound documentation, dated 11/28/24, and stated she would expect staff to notify her of the wound. She stated she did not recall if staff notified her of the wound. She stated the wound care nurse would decide and implement the treatment for the wound, but she still wanted to be notified of the wound. The MD reviewed R #6's wound documentation, dated 12/03/24, and stated she was not notified of the resident's wound at this point. She stated the wound appeared to be worsening, and the measurements did not appear to be accurate. The MD stated she needed to see and smell the resident's wound in order to make a treatment decision. She stated she expected the NP to give the resident some pain medication and look at the wound. She stated the NP should not have prescribed a treatment without looking at the wound. The MD stated it was not acceptable to treat the wound without looking at it. She stated she would not have discharged the resident with a wound like that, because the resident needed care. Z. On 03/06/25 at 1:27 pm and 03/07/25 at 1:45 pm, during an interview, the Skin Health Team Lead stated a Certified Nursing Assistant (CNA) told her about R #6's sacrum wound. She stated after she looked at the wound, she contacted a wound care company and the facility's Administrator regarding the wound. She stated she tried to text a number the nurse gave her for R #6's doctor. The SHTL stated she did not contact the facility's NP or the Medical Director, because she did not have a number for them. She stated she did not follow-up with the number the nurses gave her for the resident's doctor to ensure she had the right number or information. The SHTL stated she did not contact the resident's family regarding the wound. Based on record reviews and interviews, an Immediate Jeopardy (IJ) was identified. The facility Administrator was notified on 03/05/25 at 3:21 pm. The facility took corrective action by providing an acceptable Plan of Removal (POR). The Plan of Removal was approved on 03/06/25 at 12:10 pm. Plan of Removal All residents have the potential to be affected by this alleged deficient practice. - A whole house audit of heated electrical devices, completed on 02/27/25. - A whole house skin sweep audit to identify any undocumented wounds, completed on 12/30/25. - A second whole house skin sweep was conducted to identify undocumented wounds, completed on 02/03/25. - Direct care staff were educated on wound documentation, starting 01/08/25. - CNAs were educated on the Stop and Watch Process, from 01/21/25 through 01/27/25. - Nurses and CNAs were educated on prohibiting on the use of electrical appliances, completed 02/27/25. - Center Nurses were re-educated on skin assessments weekly per schedule, starting on 03/05/25. (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	- Nurses were educated on their responsibility with communication with management and provider for the change in condition process/documentation, starting on 03/05/25. - Nurses were educated on the facility's wound processes, timely and accurate identification of wounds, documentation for wound/wound changes, change in condition process, and appropriate treatment/intervention implementation upon identification of new or worsening wounds, starting on 03/05/25. - CNAs were educated on change in condition process for CNAs and Stop and Watch, starting on 03/05/25. - The DON/Designee will perform audit education sign-off sheets to ensure all nursing staff receive education as outlined, starting 03/05/25. - The DON/Designee will conduct five random audits on heated electrical devices and skin assessment accuracy weekly for wound care process abidance, starting 03/05/25. - An Ad Hoc QAPI meeting was held on 03/05/25 to approve the POR. - The DON/Designee and the Administrator/Designee will bring the results of the audits to the QAPI committee for three months. - The Administrator will oversee the QAPI committee. Implementation of the POR was verified onsite on 03/07/25 by conducting observations, record reviews, and staff interviews. Scope and Severity was reduced to Level 2, G. Implementation was verified through: Record review of skin sweeps, dated 12/30/25 and 02/03/25. Record review of electrical appliance audits, dated 02/27/25. Record review of skin assessment audits, date 03/05/25. Observations of wound care on 03/06/25 at 1:27 pm for R #4 and on 03/06/25 at 2:40 pm for R #5. Record review for R #4 and R #5 regarding wounds and wound care. Interviews of four CNAs regarding in-services and Stop and Watch process. Interviews of two nurses regarding in-services and wound documentation and communication. Interview with the SHTL regarding in-services and processes regarding wound documentation and orders for treatment. Interview with the Administrator and DON regarding POR, audits, and wound processes.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. 41988 Based on observation, record review, and interview, the facility failed to maintain an environment that was clean, in good condition, and free from clutter for 1 (R #1) of 1 (R #1) residents sampled for a homelike environment by facility staff leaving a bag of soiled linens on the floor in front of the residents doorway. Failure to maintain the building in a clean and comfortable manner is likely to result in unsafe conditions and prevent residents from enjoying everyday activities. The findings are: A. Record review of R #1's care plan dated 07/16/24 revealed R #1 required assistance with ADL (Activities of Daily Living) care such as bathing, grooming, personal hygiene, dressing, eating, bed mobility, transfer, and toileting due to chronic disease related to Congestive Heart Failure (CHF- when your heart can't pump blood well enough to give your body a normal supply). B. On 02/14/25 at 11:55 am during an observation of R #1's room, a plastic bag filled with soiled linen was left on the floor in front of R #1's doorway. C. On 02/14/25 at 12:01 pm during an interview with Certified Nursing Assistant (CNA) #1, she stated that all dirty linens should be put in a dirty linens bin down the hall and not left on the floor of a residents room. D. On 02/20/25 at 3:04 pm during an interview with the Director of Nursing (DON), she stated that nursing staff are supposed to take soiled linens to the biohazard room and they should not be leaving them on floor in residents rooms.

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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 0609

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.

33768

Based on record review and interview, the facility failed to ensure the results of all investigations of allegations of abuse, neglect, exploitation, misappropriation and injuries of unknown source were submitted to the State Survey Agency within 5 working days of the incident. This deficient practice likely affects all residents identified on the facility census list.

If the facility is not timely investigating allegations of abuse, then residents are at risk of further abuse. The findings are:

A. Record review of notice sent to the facility Administrator by the State Survey Agency dated 11/27/24 identified that the 5 day follow up investigations were still pending despite efforts to reach out to the Administrator for (26) facility self reports in which the 5 day follow up investigation was not received.

B. On 03/05/25 at 12:56 pm during interview with the facility Administrator and record review of facility self reports and 5 day investigation reports, he confirmed that he is the abuse coordinator and he is the only one responsible for reporting allegations of abuse to the state survey agency and for submitting the 5 day follow up investigation reports.

In reviewing the facility records, the Administrator confirmed the following investigation reports were not submitted within 5 working days requirement:

1. R #2 (incident date 10/06/24 related to care concern) wasn't submitted to the SA until 01/24/25.

2. R #9 (incident date 11/02/24 related to deept tissue injury on her heel) wasn't submitted to the SA until 02/07/25

3. R #19 (incident date 01/13/25 related to resident altercation). No evidence it had been submitted to the SA.

4. R #18 (incident date 09/25/24 related to allegation that staff put something in his coffee) wasn't submitted to the SA until 12/10/24

5. R #17 (incident on 12/23/24 related to resident altercation) wasn't submitted until 01/24/25.

6. R #10 (incident on 11/6/24 related to fall) wasn't submitted until 01/24/25.

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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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38450 Cross reference to F684 and F686. Based on record review and interview, the facility failed to ensure the discharge Minimum Data Set (MDS; a federally mandated assessment instrument completed by facility staff) was accurate for 1 (R #6) out of 1 (R #6) residents. If staff do not accurately reflect a resident's status in the MDS, then residents are at risk of not receiving the necessary care to maintain or improve their conditions. The findings are: A. Record review of R #6's admission MDS, dated [DATE], revealed the following: - admitted [DATE] from hospital. - Brief Interview of Mental Status (BIMS; a screening for cognitive impairment) score of 15, cognitively intact. - Diagnoses of end stage renal disease (ESRD; chronic irreversible kidney failure), dependence on renal dialysis renal dialysis (the process of removing extra fluid and waste products from the blood when the kidneys are not able to function properly), and depression. - The resident was at risk of developing pressure ulcers (PU; an injury to skin and underlying tissue resulting from prolonged pressure on the skin.) - The resident had two Stage 1 pressure ulcers (intact skin over a bony prominence with a reddened, painful area of skin that does not turn white when pressed.) - The resident had one Stage 4 pressure ulcer (full thickness tissue loss with exposed bone, tendon, or muscle) present on admission. - The resident had a skin tear (a type of injury where the skin is torn from the body.) - Staff did not document any other skin issues, ulcers, or wounds. B. Record review of R #6's Wound Evaluations, dated 12/04/24, revealed the following: - Unstageable pressure ulcer [a wound that has full thickness tissue loss but is covered with slough (dead tissue) or eschar (dark scab or falling away of dead skin) so that the true depth of the wound cannot be determined] to right lateral heel (Documented as a Stage 1 pressure ulcer on admission.) - Stage 4 pressure ulcer to right medial ankle. - Unstageable pressure ulcer to left heel (Documented as a Stage 1 pressure ulcer on admission.) - Stage 1 pressure ulcer to rear left ankle. (continued on next page)

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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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Third degree burn to sacrum. C. Record review of R #6's Physiatry (related to physical medicine and rehabilitation) progress notes, date 12/05/24, revealed the following: - The resident's plan and progress was discussed with nursing staff and therapy. Resident was sitting up in bed and she reported pain at right leg. Resident stated she slept on and off throughout the night. No complaints of fever, chills, nausea, vomiting. - Pain: Resident reported pain at right lower extremity at hip region. Continue lidocaine patch (a local anesthetic that prevents pain by blocking the signals at the nerve endings in the skin) to affected area once daily. - Electronically signed by the Consultant. D. Record review of R #6's Physician Orders, dated December 2024, revealed the following: - Order dated 12/05/24, lidocaine external patch. Apply to right hip topically (on the skin) in the morning for pain. End date 12/12/24. - Order dated 12/05/24, remove lidocaine patch from right hip at bedtime for pain. End date 12/12/24. E. Record review of R #6's MAR and TAR, dated December 2024, revealed the following: - Lidocaine external patch. Apply to right hip topically in the morning for pain. Staff documented they applied the patch 12/06/24, 12/07/24, 12/08/24, and 12/09/24. - Remove lidocaine patch from right hip at bedtime for pain. Staff documented they removed the patch on 12/05/24, 12/06/24, 12/07/24, 12/08/24, and 12/09/24. F. Record review of R #6's discharge progress note, dated 12/09/24, revealed the following: - Wound care: redness on buttock bilaterally (both sides.) - Medications were given to daughter at discharge. - Resident was transferred by wheelchair and two nurse aides assisted. - Resident remained stable. - Resident was discharged to Assisted Living Facility with family support. G. Record review of R #6's discharge MDS, dated [DATE], revealed staff documented the following: - Discharge, return not anticipated. - discharge date [DATE]. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- discharged home under care of organized home health service organization. - Did not receive scheduled pain medication regimen. - The resident had one unstageable pressure ulcers, noted at the time of admission. - The resident had one Stage 4 pressure ulcer, noted at the time of admission. - The resident had one unstageable pressure ulcer that was not present at admission. - Staff did not document the resident was discharged to Home/Community to include Assisted Living Facility. - Staff did not document the resident received schedule lidocaine external patch. - Staff did not document the unstageable (Stage 1) pressure ulcer present on admission. - Staff did not document the Stage 1 pressure ulcer that was not present on admission. H. On 04/04/25 at 10:30 am during an interview with the Director of Nursing (DON) and the MDS Coordinator, the MDS Coordinator stated the MDS includes information regarding the resident's status during the five day look back period (The time period over which staff observe a resident to capture the resident's condition or status for the MDS assessment. Unless otherwise stated, the look back period is seven days, and only those occurrences during the look back period will be captured on the MDS.) She stated the information in the MDS should be an accurate depiction of the last five days of the resident's care. The MDS stated she reviewed the resident's medical record to include the orders, the physician notes, the nursing notes, and the MAR/TAR. She stated she also asks the staff for information. The MDS Coordinator stated she assumed the medical records were accurate, but she will question the nursing staff if something in the records is changed or seems out of place.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41988 Based on record review and interview, the facility failed to create an accurate baseline care plan (minimum healthcare information necessary to properly care for a resident immediately upon their admission to the facility) within 48 hours of admission for 1 (R #3) of 1 (R #3) resident reviewed for baseline care plans. This deficient practice could likely result in residents not receiving the appropriate care and may place residents at risk of an adverse event (undesirable experience, preventable or non-preventable, that caused harm to a resident because of medical care or lack of medical care) or worsening of current condition after admission. The findings are: A. Record review of R #3's face sheet revealed R #3 was admitted into the facility on [DATE] and was discharged on [DATE]. B. Record review of R #3's care plan dated 01/23/25 revealed the following care areas were care planned: 1. R #3 had an infection related to a Mutlidrug-resistant Organisms (MDRO). 2. R #3 was at nutritional risk due to inadequate oral intake. No other care areas were care planned for R #3. C. Record review of R #3's oxygen (O2) saturations summary dated 01/22/25 through 01/26/25 revealed R #3 was provided O2 at 2 LPM each day. D. On 02/19/25 at 2:30 pm during an interview with R #3's Power of Attorney (POA- medical decision maker), she stated R #3 was placed on O2 when he was at the hospital and when he was admitted into the facility. R #3's POA confirmed R #3 wore O2 while in the facility. E. On 02/20/25 at 3:07 pm during an interview with the Director of Nursing (DON), she confirmed R #3's O2 use was not care planned on his baseline care plan, and stated that it should have been.

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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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41988 Based on observation, record review, and interview, the facility failed to provide a quality care that meets professional standards for 4 (R # 1, 2, 3 and 6) of 4 (R #1, 2, 3 and 6) residents when the facility failed to: 1. Ensure R #1's oxygen (O2) amount was provided as per physician orders. 2. Label and date O2 tubing per physician orders for R #1 and R #2. 3. Ensure there was a physician order for oxygen use before being provided to R #3. 4. Ensure there was a physician order before providing medication/treatment to R #6. If the facility is not following physician orders, then residents are at risk of adverse outcomes and inadequate monitoring of treatment. The findings are: R #1: A. Record review of R #1's face sheet revealed R #1 was admitted into the facility on [DATE]. B. Record review of R #1's physician orders dated [DATE] revealed an order for O2 at 5 liters per minute (LPM) via nasal cannula (thin, flexible tube that provides O2 through ones nose) continuously. C. Record review of R #1's physician orders dated [DATE] revealed an order for R #1's O2 tubing to be changed, and label each component with date and initials weekly. D. On [DATE] at 11:54 am during an observation of R #1's room, R #1 was observed to be wearing O2 at 2.5 LPM via a nasal cannula. R #1's O2 tubing was not labeled or dated. E. On [DATE] at 12:00 pm during an interview with Certified Nursing Assistant (CNA) #1, she stated that she did not know what LPM R #1's O2 should be at and the CNAs put R #1's O2 at 2.5 LPM. CNA #1 confirmed R #1's O2 tubing was not labeled or dated and should have been. F. On [DATE] at 12:03 pm during an interview with Licensed Practical Nurse (LPN) #1, he confirmed R #1's O2 was not set at 5 LPM and her physician orders indicated it should be at 5 LPM. G. On [DATE] at 3:02 pm during an interview with the Director of Nursing (DON), she stated her expectation was for nursing staff to provide O2 at the LPM that is ordered by a physician, and if there are concerns, the facility nursing staff should contact a provider. The DON also stated all O2 tubing should be labeled and dated as ordered. R #2: H. Record review of R #2's face sheet revealed R #2 was admitted into the facility on [DATE]. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	I. Record review of R #2's physician orders dated [DATE] revealed an order for R #2's O2 tubing to be changed, and label each component with date and initials weekly. J. On [DATE] at 5:18 pm during an observation of R #2's room, R #2's O2 tubing was not labeled or dated. K. On [DATE] at 5:25 pm during an interview with CNA #2, he confirmed R #2's O2 tubing was not labeled or dated, and should have been. R #3: L. Record review of R #3's face sheet revealed R #3 was admitted into the facility on [DATE] and was discharged on [DATE]. M. Record review of R #3's O2 saturations summary dated [DATE] through [DATE] revealed R #3 was provided O2 at 2 LPM each day. N. Record review of R #3's physician orders reviewed on [DATE] revealed no order was present for O2 use. O. On [DATE] at 3:05 pm during an interview with the DON, she confirmed R #3 did not have physician orders for O2 use and stated R #3 should have had physician orders for O2 use. 38450 R #6 P. Record review of R #6's physician progress note, dated [DATE], revealed the following: - Resident was started on rifaximim (antibiotic) 550 milligrams (mg) twice daily. Unclear where order originated. - Nursing staff ordered rifaximin under Nurse Practitioner's (NP) name without order or permission. NP spoke to Nurse Manager (NM) who confirmed the medication was a prior home medication but expired prior to hospitalization [prior to admission.] Family requested medication be resumed without medical review. No available documentation to support rifaximin at this time. Placed on hold pending appropriate records and lab work. - Electronically signed by the NP on [DATE]. Q. Record review of R #6's Medication Administration Record (MAR), dated [DATE], revealed staff documented the following: - Xifaxan Oral Tablet (Rifaximin) 550 mg. Give one tablet by mouth two times a day for chronic kidney disease (CKD.) - Start date [DATE]. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Hold Date [DATE] through [DATE]. - Staff administered the medication as entered in the [DATE]/,d+[DATE] pm through [DATE] am. R. On [DATE] at 10:30 am, during an interview, the Director of Nursing (DON) stated the provider entered medication orders in the resident's record, or the nurse entered the orders if the providers gave the orders over the phone. She stated medications orders for new admissions come from the hospital and are verified and confirmed by the provider before they are entered into the resident's record by the provider or nurse. The DON stated she was not aware of staff entering a medication order into the resident's record without a provider's order. She stated if a family member requested a medication, then staff should call the provider and request an order. She stated staff should not order medication under the provider's name without permission. She stated that was a violation of the nurses' license and corrective action should be taken.

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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 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41988 Based on record review and interview, the facility failed to provide quality of care for 4 (R #1, 6, 7 and 10) of 4 (R #1, 6, 7 and 10) residents reviewed for change in condition by: 1. Not treating R #1, 7 and 10 when a change in condition was identified 2. Not reporting new wound to physician, delaying in initiating treatment, Physician Assistant (PA) not evaluating the wound before intimating treatment orders for R #6 3. Discharging resident to an assisted living facility instead of the hospital despite the resident showing significant signs of a change in condition. These deficient practices likely resulted in worsening condition and unnecessary discomfort for the residents. The findings are: R #1 A. Record review of R #1's face sheet revealed R #1 was admitted into the facility on [DATE]. B. Record review of R #1's nursing progress notes dated 01/1725 through 01/31/25 revealed the following: 1. 01/17/25 at 10:00 am: R #1 complained of cough and rhonchi (continuous, low-pitched lung sounds that resemble snoring or gurgling) to upper part of lungs. Tylenol and chest x-ray ordered. 2. 01/21/25 at 8:49 pm: R #1 is confused. 3. 01/22/25 at 12:00 am: Provider Encounter- R #1 reports having a cough and congestion. R #1 is wearing oxygen (O2) and feels slightly short of breath. 4. 01/25/25 at 1:00 am: New onset of confusion. Labs ordered. 5. 01/25/25: at 3:28 pm: At approximately 1:00 pm R #1 experienced a sudden onset of confusion. R #1 stated she should walk out of the facility and she was seeing her pet cat walk around the room. Monitor until lab results received. 6. 01/27/25 at 11:42 pm: R #1 was experiencing disorientation, disorganized thinking, and confusion. R #1 has been sick and has also been confused as of late. 7. 01/28/25 at 10:35 pm: R #1 is confused. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	8. 01/29/25 at 12:00 am: Provider Encounter- R #1 is sleeping in bed and is difficult to wake. R #1 is wearing O2 and has a mild increased work of breathing. R #1 awakens and stated that she has been very tired recently and has had a cough since 01/15/25. Labs reviewed and R #1 has an elevated white blood cell count (which indicates various conditions, including infections, inflammation, or bone marrow disorders). Chest x-ray ordered to rule out Pneumonia. Continue medications and may need to start antibiotics. 9. 01/29/25 at 6:53 pm: R #1 is lethargic and incoherent. 10. 01/30/25 at 10:16 am: R #1 is confused. 11. 01/31/25 at 12:00 am: Provider Encounter- Nurse called to report R #1 is physically declining. R #1's blood pressure is 74/42 and repeated it was 89/40. R #1 is wheezing and lethargic, and stated she has been sick with a respiratory illness. She had a chest x-ray, but the results have not come in yet. Requesting to send R #1 to the hospital because R #1 has significantly declined. R #1 is lethargic, difficult to arouse when name is being called, pale, and clammy. Send R #1 to the hospital for evaluation and treatment. 12. 01/31/25 at 8:16 am: Late Entry- 911 called and R #1 was sent to the ER at 8:45 am on 01/31/25. C. Record review of R #1's ER documentation dated 01/31/25 revealed, R #1 was diagnosed with Pneumonia, UTI, Kidney Inflammation, and Sepsis (a life-threatening complication of an infection). D. On 02/14/25 at 11:34 am during an interview with R #1's friend, she stated R #1 got progressively worse during the dates of 01/15/25 through 01/31/25. R #1's friend stated that the facility delayed sending R #1 to the ER. E. On 02/19/25 at 2:45 pm during an interview with Licensed Practical Nurse (LPN) #4, she stated she worked with R #1 on 01/25/25 when R #1 was confused wanting to leave the facility and seeing her pet cat in her room. LPN #4 stated the Certified Nursing Assistant (CNA) told her that R #1 was experiencing a lot of confusion, so she went to assess R #1. LPN #4 also stated that because R #1 was so confused, she contacted the provider, but the provider did not tell her to send R #1 to the ER. LPN #4 confirmed she believed R #1 should have been sent to the ER sooner than 01/31/25. F. On 02/19/25 at 3:38 pm during an interview with LPN #2, she stated that R #1 was experiencing confusion on 01/29/25, so the provider came to see R #1 and ordered a chest x-ray. G. On 02/19/25 at 4:30 pm during an interview with LPN #3, she stated R #1 was complaining of a cough on 01/17/25, so she contacted the provider to get medication to treat R #1's cough. LPN #3 stated R #1 was not getting better over time, so she requested to send R #1 to theER on [DATE]. LPN #3 also stated that she tried to send R #1 to the ER before, but she was told she could not do that by the former Unit Manager. LPN #3 confirmed R #1 significantly declined to the point where she called 911 to send R #1 to the ER. LPN #3 also confirmed that R #1 should have been sent to the ER sooner than she was sent out. (continued on next page)

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F 0684

Level of Harm - Immediate jeopardy to resident health or safety

Residents Affected - Some

H. On 02/19/25 at 5:30 pm during an interview with R #1, she stated that she became really sick (from 01/15/25 through 01/31/25) and she was not in her right state of mind. R #1 stated the hospital diagnosed her with Pneumonia, a UTI, Sepsis, and Kidney Stones. R #1 also stated that her friends and roommate had concerns that the facility delayed sending her to the ER.

I. On 02/20/25 at 11:43 am during an interview with the Physician's Assistant (PA), she stated that she initially evaluated R #1 due to R #1 experiencing a cough, but she was unaware of R #1's confusion due to her not being familiar with R #1. The PA stated that R #1 was not alert when she assessed her and she had diminished lung sounds, which is why she ordered a chest x-ray and antibiotics. The PA confirmed R #1 should have been sent to the ER sooner than she was and she did not know why R #1 was not sent to the ER sooner.

J. On 02/20/25 at 2:35 pm during an interview with Registered Nurse (RN) #1, she stated R #1 began to decline prior to being sent to theER on [DATE]. RN #1 also stated that R #1 was not doing well, but she did not remember why R #1 was not sent to the ER. RN #1 confirmed R #1 should have been sent to the ER sooner than 01/31/25.

K. On 02/20/25 at 3:13 pm during an interview with the Director of Nursing (DON), she stated that two of the providers that assessed R #1 during 01/17/25 through 01/31/25 were in-house providers and two were on-call providers, which might have delayed sending R #1 out to the ER sooner than 01/31/25. The DON also stated that she would expect there facility nurses to send a declining resident to the ER if needed, and not wait to do so. The DON confirmed R #1 should have been sent to the ER sooner than 01/31/25 and she was not.

33768

Findings related to R #7

L. Record review of the complaint allegation received by the State Agency on 01/09/25 revealed that during the holiday (Christmas), three different family members visited R #7 either in person of via Zoom and all three mentioned that her eyes were red, irritated and making R #7 uncomfortable. The cousin who visited in person alerted staff to this and they brought some eye drops. The complainant stated that she specifically requested care for R #7's eyes via email on 12/24/24 and 12/31/24 however there was no response until 01/07/25.

M. On 02/15/25 at 12:33 pm during interview with R #7 when asked about her eyes being irritated, she stated Only thing I remember was they were cutting grass and the window was open. She confirmed that her eyes were itchy but it wasn't painful. R #7 remembered the symptoms only lasting one day.

N. On 03/05/25 during interview with R #7's daughter, she stated that she her mother has stroke damage and struggles with short term memory loss. She reported that her cousin and niece had visited her mother in December and noticed that her eye was red and bothering her. R #7's daughter stated that she made outreach to the Director of Nursing during Christmas week and she [DON] didn't get back to her. She stated that R #7 looks forward to her hair appointments and was told she was not allowed to go to her hair appointment she had pink eye. This was on 01/07/25. She stated that she came to visit in January and everyone including the executive Director (Administrator) apologized. She stated that when she came to the facility [on 01/07/25], the issue was finally addressed.

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NAME OF PROVIDER OR SUPPLIER: Las Palomas Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 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 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	O. Record review of email provided by R #7's daughter dated 12/26/24 identified that R #7's other daughter had informed her sister that R #7 had itchy runny eyes that was assumed to be attributed to allergies. Another email identified that R #7's daughter had emailed the Unit Manager on 12/31/24 regarding R #7's eyes and received no response until 01/07/25. P. Record review of the Change in Condition Evaluation for R #7 dated 01/07/25 revealed Eye are red along the upper and lower lids. Inside her eyes they are full of mucus. Dr. (Doctor) seen her today and prescribed medicine for 10 days. Date and time of of clinician notification was identified as 01/07/25. Q. Record review of the Medication Administration Record for R #7 dated January 2025 identified an order Pataday Ophthalmic Solution 0.1 % (antihistamine) one drop in both eye s two times a day for allergic conjunctivitis (pink eye) for 10 days started on 01/07/25. R. On 03/05/25 at 12:33 pm during interview with the Administrator regarding R #7, he stated the issue with her eyes was brought up in the morning clinical meeting as a change in condition (01/07/25) and that the provider saw R #7 and then prescribed an ointment. When asked if the family had brought concerns to his attention prior to 01/07/25, he stated that no one had told him about it but that the Activities Director did received an email on 12/26/24 and should have informed the nurse to tell the doctor. The Administrator confirmed that it would be his expectation that staff should have immediately informed the nurse of a change in condition to the resident however there was no evidence that this was done for R #7. 39509 R #10 S. Record review of R #10 face sheet dated 04/01/25 revealed she was admitted to the facility on [DATE] with multiple diagnoses including: -Cerebral (brain) Infarction (death of tissue due to lack of oxygen-stroke) -Acute Kidney Failure -Alzheimer's Disease (a chronic progressive disease that causes loss of memory and thought) The face sheet also revealed that primary care provider (PCP) was a doctor of a senior service agency, not a provider connected to the facility. T. Record review of R #10 daily care notes revealed: -11/03/24 she was confused, she refused her medications and was not sleeping. A Urinary Tract Infection (UTI) was suspected, and the nurse placed an order to gather and test urine for a urinalysis to test for possible UTI. -11/04/24 R #10's provider called the facility, canceled the urinalysis and reported that R #10 had already had a urinalysis at their facility, the test had returned positive for a UTI and that orders would be entered for an antibiotic for treatment. (continued on next page)

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F 0684

Level of Harm - Immediate jeopardy to resident health or safety

Residents Affected - Some

-11/05/24 R #10 was noted to be confused, had had multiple falls, and required one-to-one monitoring.

-11/05/24 After a fall, R #10 was sent to the local hospital for assessment due to her altered mental status. Per the note, she returned later that night after receiving an intravenous (within the veins) antibiotic.

U. Record review of R #10 provider order dated 11/08/24 revealed an order to begin Amoxicillin-Clavulanate (an antibiotic medication that treats infections) 875-125 mg (Milligrams) once daily for 7 days for a UTI.

V. Record review of R #10 daily care note revealed

-12/05/24 R #10's Primary Care Provider (PCP) was notified of R #10's change of condition-she was yelling, wandering about the hall, refusing to comply with directions and could not be redirected. The PCP stated that Risperidone (a psychiatric medication used to treat agitation) would be prescribed.

-12/13/24 R #10 is screaming, attempting to throw herself on the floor. The provider was called and ordered R #10 be sent to the hospital for evaluation.

-12/13/25 R #10 returned to the facility from the hospital.

W. Record review of R #10 provider order dated 12/19/24 revealed an order to administer Risperidone 0.5 mg (milligrams) twice daily for agitation.

X. On 04/02/25 at 12:10 pm during interview with the Director of Nursing (DON), stated that R #10 is one of several residents who are managed by a PCP who is not connected with the facility. DON confirmed that R #10's care was delayed. She stated that R #10's senior service PCP should have informed the facility on or before 11/03/24 that the suspected R #10 had a UTI and that they had tested R #10 to confirm this. She stated that R #10's was also delayed when the PCP failed to enter an order for the administration of an antibiotic for 5 days. She also confirmed that R #10's care was delayed when the PCP failed to enter an order for Risperidone for 14 days.

38450

R #6

Cross reference to F580, F641, F658, F686, and F880.

Z. Record review of R #6's admission Minimum Data Set (MDS; a federally mandated assessment instrument completed by facility staff), dated 11/19/24, revealed the following:

- admitted [DATE] from hospital.

- Brief Interview of Mental Status (BIMS; a screening for cognitive impairment) score of 15, cognitively intact.

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	- Always incontinent of bladder and bowels. - Diagnoses of end stage renal disease (ESRD; chronic irreversible kidney failure), dependence on renal dialysis renal dialysis (the process of removing extra fluid and waste products from the blood when the kidneys are not able to function properly), and depression. - The resident was at risk of developing pressure ulcers (PU; an injury to skin and underlying tissue resulting from prolonged pressure on the skin.) - The resident had two Stage 1 pressure ulcers (intact skin over a bony prominence with a reddened, painful area of skin that does not turn white when pressed.) - The resident had one Stage 4 pressure ulcer (full thickness tissue loss with exposed bone, tendon, or muscle) present on admission. - The resident had a skin tear (a type of injury where the skin is torn from the body.) - Staff did not document any other skin issues, ulcers, or wounds. AA. Record review of R #6's Wound Evaluation, dated 11/28/24, revealed the following: - Burn, third degree. - Staged by in-house nursing. - Location: Sacrum (a large flat bone in the lower part of the spine.) - Minutes old and acquired in-house (at the facility.) - Measurements: length 6.64 centimeters (cm), width 4.2 cm, depth 0.2 cm, area 15.95 cm^2 (square centimeters.) - Wound bed: Epithelial tissue (a thin, continuous layer of cells) present, granulation tissue (new connective tissue and blood vessels, a sign of wound healing) present. - Moderate serosanguineous (clear or light pink, thin, watery fluid) exudate (body fluid discharged by the body in response to tissue damage and wound healing.) - Edges attached, surrounding tissue erythema (redness.) - Temperature was hot, localized. - Resident reported pain at a 7 out of 10 during dressing. - Treatment: Generic wound cleanser, composite dressing, and Xeroform bordered gauze. - Notes: Resident's skin was hot to touch with a heating pad under her. The resident's skin was thin and fragile. Removed the heating pad. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	- Education: The resident was educated about the risk factors involved in using a heating pad. Resident was strongly advised to discontinue use of the heating pad and to shift weight in bed frequently. - Notification: None documented. - Electronically signed by the facility's Skin Health Team Lead (SHTL) on 11/29/24 at 12:33 pm. BB. Record review of R #6's Physician Orders, dated November 2024, revealed the following: - Order dated 11/13/24, pressure redistribution cushion to chair. - Order dated 11/13/24, pressure redistribution mattress to bed. - Order dated 11/29/24, wound care for sacrum lower back. Cleans with generic wound cleanser, pad dry, apply small amount of xeroform, and apply bordered gauze. CC. Record review of R #6's Medication Administration Record (MAR) and Treatment Administration Record (TAR), dated November 2024, the record did not contain wound care orders or documentation staff administered the orders, dated 11/28/25, for the resident's third degree burn to the sacrum. DD. Record review of R #6's medical record revealed the record did not contain any documentation staff administered wound treatments, dated 11/28/25, for the resident's third degree burn to sacrum. EE. Record review of R #6's care plan revealed the following: - Dated 11/13/24, last updated 11/19/24. - The resident was at risk for skin breakdown related to advanced age, decreased activity, frail fragile skin, and limited mobility. - The resident would not show signs of skin breakdown for 90 days. - Interventions: Pressure redistribution surface to chair and bed, weekly skin check by licensed nurse, offload heels while in bed, observe skin condition daily with ADL care and report abnormalities, apply barrier cream with each cleansing. - The record did not document the resident's third degree burn on her sacrum. FF. Record review of R #6's Nursing Skilled Evaluation, dated 11/29/24, revealed the following: - Pain: Indicators of pain: None. - The record did not contain any information in the following areas: skin, special care, safety, completed clinical suggestions, comments. - The record did not address the resident's third degree burn on her sacrum and her wound treatments. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	- Electronically signed by an agency licensed nurse. GG. Record review of R #6's Progress Note, dated 12/02/25, revealed the following: - Visit type was acute follow-up. - Chief complaint and nature of the presenting problem: Follow-up of admitting medical diagnoses, including depression. - Resident was a fairly inconsistent historian but at time of encounter denied complaint or concern. - Nursing staff denied new or worsening behaviors, recent fall or injury, unstable vital signs, or other complaint or concern. - The record did not address the resident's third degree burn on her sacrum and her wound treatments. - Electronically signed by the Nurse Practitioner on 12/03/24 at 4:55 pm. HH. Record review of R #6's nutrition progress note, dated 12/03/24, revealed the following: - Resident had multiple pressure wounds. - The record did not address the resident's sacrum wound. II. Record review of R #6's Wound Evaluation, dated 12/04/24, revealed the following: - Burn, third degree. - Staged by in-house nursing. - Located on sacrum. - Six days old and acquired in-house. - Measurements: length 6.24 cm, width 3.9 cm, depth 0.2 cm, area 18.24 cm^2. - Wound bed 70 percent (%) epithelial, 70% granulation, 20% slough (yellow stringy tissue adhered to wound bed.) - Evidence of infection: increased drainage, increased pain. - Bleeding. - Moderate serosanguineous exudate with faint odor after cleaning. - Edges attached, surrounding tissue erythema. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	- Resident reported pain at a 7 out of 10 during dressing. - Dressing appeared saturated. - Treatment: Vashe (wound cleanser), Medihoney (wound and burn gel), foam, incontinence management. - Healable. - Stable. - Notification: None documented. - Electronically signed by the facility's SHTL on 11/04/24 at 1:05 pm. JJ. Record review of R #6's Physiatry (related to physical medicine and rehabilitation) progress notes, date 12/05/24, revealed the following: - The resident's plan and progress was discussed with nursing staff and therapy. Resident was sitting up in bed and she reported pain at right leg. Resident stated she slept on and off throughout the night. No complaints of fever, chills, nausea, vomiting. - Pain: Resident reported pain at right lower extremity at hip region. Continue lidocaine patch to affected area once daily. - Electronically signed by the Consultant. KK. Record review of R #6's Physician Orders, dated December 2024, revealed the following: - Order dated 12/04/24, for lower back sacrum wound. Cleanse wound with Vashe, soak gauze in Vashe. Lace on wound and allow to soak area for 20 minutes. Pat dry. Apply Medihoney and cover with bordered gauze. Every day and night shift, and as needed for when soiled or dressing is removed. - Order dated 12/05/24, silver sulfadiazine cream 1%. Apply to burn on sacrum topically every day and night shift for wound care. Cleanse with generic wound cleanser, pat dry. Apply thin layer of silver sulfadiazine cream, cover with border gauze. - Order dated 12/05/24, lidocaine external patch. Apply to right hip topically in the morning for pain. End date 12/12/24. - Order dated 12/05/24, remove lidocaine patch from right hip at bed time for pain. End date 12/12/24. LL. Record review of R #6's MAR and TAR, dated December 2024, revealed the following: - Silver Sulfadiazine cream 1%. Staff did not document they applied the cream on the night of 12/06/25. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	- Lidocaine external patch. Apply to right hip topically in the morning for pain. Staff documented they applied the patch 12/06/24, 12/07/24, 12/08/24, and 12/09/24. - Remove lidocaine patch from right hip at bedtime for pain. Staff documented they removed the patch on 12/05/24, 12/06/24, 12/07/24, 12/08/24, and 12/09/24. - The record did not contain the wound care orders or documentation staff administered the orders, dated 12/04/24, for the resident's third degree burn to sacrum. MM. Record review of R #6's medical record revealed it did not contain any documentation staff administered the wound treatments, dated 12/04/24, for the resident's third degree burn to sacrum. NN. Record review of R #6's Progress Note, dated 12/06/25, revealed the following: - Visit type: Discharge. - Chief complaint and nature of the presenting problem: Discharge summary and plan. - The resident was initially to be seen today for discharge summary and plan. The NP was contacted by the wound care nurse and notified the resident had a burn to her back. The burn reported had an odor and greenish discharge. The resident was asymptomatic without indication of sepsis or systemic infection. Patient lay in bed, and did not appear to be in acute distress. Resident was a poor historian secondary to dementia, and the NP was unable to reposition the resident at the time of the encounter in order to examine the resident's back. Order to apply silver sulfadiazine cream (antibiotic cream for serious skin infections and burns) 1% placed with wound care nurse. No other concerns noted at time of encounter. - Discharge home. - Discharge condition stable. - Diagnosis: Superficial burn. - Plan for superficial burn: No signs of systemic infection. Continue silver sulfadiazine 1% cream twice daily. Follow-up with primary care physician for further management. - Electronically signed by the NP on 12/09/24 at 8:24 pm. OO. Record review of R #6's Nursing Skilled Evaluation, dated 12/07/24, revealed the following: - Pain: Indicators of pain: None. - The record did not contain any information in the following areas: skin, special care, safety, completed clinical suggestions, and comments. - The record did not address the resident's third degree burn on her sacrum and her wound treatments. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	- Electronically signed by an agency licensed nurse. PP. Record review of R #6's discharge progress note, dated 12/09/24, revealed the following: - Wound care: redness on buttock bilaterally. - Medications were given to daughter at discharge. - Resident was transferred by wheelchair and two nurse aides assisted. - Resident remained stable. - Resident was discharged to assisted living with family support. QQ. Record review of R #6's Discharge Plan Documentation, dated 12/09/24, revealed the following: - Discharge time 12:00 pm. - Next doctor appointment with primary care doctor on 12/23/24. - No other doctor appointments were documented. - Skin intact. - Infections: Not applicable. - Resident was stable at time of discharge. - Electronically signed by facility nurse on 12/10/24. RR. Record review of R #6's discharge MDS, dated [DATE], revealed staff documented the following: - Discharge, return not anticipated. - discharge date [DATE]. - discharged home under care of organized home health service organization. - Staff did not mark the resident was discharged to Home/Community to include assisted living facility. - Did not receive scheduled pain medication regimen. - Staff did not document the resident received schedule lidocaine external patch. - The resident had one unstageable pressure ulcers, noted at the time of admission. - The resident had one Stage 4 pressure ulcer, noted at the time of admission. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	- The resident had one unstageable pressure ulcer that was not present at admission. - Staff did not document the resident's sacrum wound. SS. On 03/05/25 at 2:17 pm, during an interview, R #6's daughter her mother was admitted to the hospital on 11/02/24 for peritonitis (inflammation of the tissue that lines the abdomen), which made her blood pressure drop. She stated her mother was in the hospital from 11/03/24 through 11/12/24. The daughter stated her mother was admitted to the facility on [DATE] for rehabilitation to get her strength up. She stated she was not aware of any of her mother's wounds when her mother arrived at the facility. The daughter stated there was a care plan meeting on 11/18/24, and the staff told her about her mother's pressure ulcers. The daughter stated she visited her mother almost every day, sometimes in the morning and sometimes in the afternoon. She stated she visited her mother early in the day on 12/04/24, and the wound nurse stated she did not like the way her mother's sacrum wound looked because it was turning green. The daughter stated the wound nurse took a picture and sent it to her and told her she would send the picture to the doctor. The daughter stated it had been four days since she saw her mother and it looked a lot worse than the last time she saw the wound. She stated she asked the wound nurse what she was looking at in the picture, and the wound nurse told her it was slough, which could lead to infection. The daughter stated she spoke to a Certified Nursing Assistant (CNA) on 12/07/25, and the CNA stated her mother was not feeling well and did not go to dialysis. The daughter stated the CNA reported she applied a salve to her mother's wound twice a day, and her mother's wound had a smell to it. The daughter stated over the next couple days her mother did not look well. She stated by the day she discharged (12/09/24) her mother looked horrible and was sweating. She stated the CNAs did not know why her mom was sweating. The daughter stated they tried to move her mother into a chair, but her mother begged to get back into bed. The daughter stated her mother was supposed to discharge at noon on 12/09/24, but she was not ready on time. She stated her mother was in an unusual amount of pain when the two CNAs transferred her into a wheelchair, and her mother was confused and agitated. She stated her mother was not mentally herself, and her back was covered with sweat. The daughter stated the facility did not have transportation to take her mother to the Assisted Living Facility (ALF) which was right down the street from the facility. She stated two CNAs from the facility were not able to transfer her mother into her car, because her mother was in a lot of pain. She stated her mother was propelled in a wheelchair up the street to the ALF. She stated when her mother got to the ALF, staff put her right to bed, and her mother calmed down. The daughter stated her mother was in too much pain to sit up. The daughter stated her mother was scheduled for dialysis on 12/10/24, but the dialysis center sent her mother to the emergency room , because her heart rate was very low. The daughter stated her mother was admitted to the hospital with a diagnosis of septic shock. They told her that her mother had a racing heart rhythm, low blood pressure, and was incoherent. The daughter stated her mother was too weak for a full session of dialysis, and she passed away in the hospital eight days later. The daughter stated while her mother was at the facility, she brought a heating pad for her mother to use. She stated her mother used it for a little while, but then the heating pad disappeared. She stated that was around the beginning of December. The daughter stated she did not remember staff telling her that her mother was burned by the heating pad. She stated her mother used it all the time at home and was responsible with it. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	TT. On 03/06/25 at 11:26 am, during a record review and interview, the Physician Assistant (PA) stated she began working at the facility in January 2025, and she was not present when R #6 was at the facility. The PA stated she worked at the facility Monday through Fridays, and she conducted resident visits every day. She stated her responsibilities included evaluating the residents, following up on diagnosis, and prescribing treatments. She stated staff update her on resident conditions while she is at the facility or they call her on the on-call number. She stated she would expect staff to notify her of any changes in condition, medication issues, and physical conditions. The PA reviewed R #6's wound documentation dated 11/28/24. She stated she would not have said the wound was a burn, because it looked like skin breakdown to her. She stated if it was a burn due to a wet brief on a heating pad then it would be a bigger area. She stated all the areas in contact with the heating pad should have burn marks. She stated she would have expected staff to notify her of that wound. She stated she would have prescribed a barrier treatment for the wound. The PA reviewed R #6's wound documentation dated 12/04/24, and stated she saw necrosis (dead tissue), an enlarging of the wound, and she thought the tissue looked different. She stated the wound looked deeper, but it was hard to tell if there was depth with that type of ulcer. She stated the wound was getting worse, and it was not a burn wound at that point. She stated she would have wanted to see the wound, and she would have sent the resident out to the ER if she had seen it. The PA stated a prescription for burn cream would not have hurt the resident's wound, but it would not have helped it either. She stated a wound like that could result in osteomyelitis (inflammation of bone and bone marrow) and sepsis. She stated the signs of sepsis was tachycardia, fever, confusion, and sweating. She stated R #6 should not have been discharged to an ALF with that wound. She stated the resident should have went to the hospital. UU. On 03/07/25 at 11:38 am, during a record review and interview, the Medical Director (MD) stated she has been the facility's MD for several years. She stated she was not familiar with R #6, but she reviewed the resident's discharge summary. The MD reviewed the R #6's wound documentation dated 11/28/25. She stated she agreed with the wound assessment of a burn. She stated she would expect the staff to report the wound to her, but she did not recall staff notifying her. She stated she did not provide treatment orders. She stated the wound care nurse decided and implemented treatments for wounds. She stated she expected the treatment for the wound to begin at this stage. The MD reviewed R #6's wound documentation dated 12/4/24. She stated the wound was getting worse and bigger. She stated the wound should have been reported to her before it got to that state. She stated treatments should have been implemented before the wound got to that state. The MD stated the wound was not reported to her. She stated the measurements in the record did not appear to be accurate. She stated the wound needed to be debrided. She stated she needed to see and smell the wound to determine the best course of act

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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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38450 Based on record review and interview, the facility failed to ensure 1 (R #6) of 1 (R #6) resident reviewed for pressure ulcers (a wound caused by prolonged pressure occurring in bony areas of the body) received the necessary treatment and services to promote healing and prevent new ulcers from developing when staff failed to perform wound care for multiple days. Failure to provide treatment for pressure ulcer could cause the wound to worsen and develop sepsis or osteomyelitis (bone infection.) The findings are: A. Record review of R #6's admission Minimum Data Set (MDS; a federally mandated assessment instrument completed by facility staff), dated 11/19/24, revealed the following: - admitted [DATE] from hospital. - Brief Interview of Mental Status (BIMS; a screening for cognitive impairment) score of 15, cognitively intact. - Diagnoses of end stage renal disease (ESRD; chronic irreversible kidney failure), dependence on renal dialysis renal dialysis (the process of removing extra fluid and waste products from the blood when the kidneys are not able to function properly), and depression. - The resident was at risk of developing pressure ulcers (PU; an injury to skin and underlying tissue resulting from prolonged pressure on the skin.) - The resident had two Stage 1 pressure ulcers (intact skin over a bony prominence with a reddened, painful area of skin that does not turn white when pressed.) - The resident had one Stage 4 pressure ulcer (full thickness tissue loss with exposed bone, tendon, or muscle) present on admission. - The resident had a skin tear (a type of injury where the skin is torn from the body.) - Staff did not document any other skin issues, ulcers, or wounds. B. Record review of R #6's Post Admission Patient Family Conference, dated 11/16/24, revealed the following: - R #6 and her family attended. - Projected length of stay was 15-21 days. - The resident had services and treatments for wound care. - Post skilled nursing disposition: Assisted living. - The resident was considering an assisted living facility. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- The record did not document the resident's wounds present on admission. - The care plan was reviewed and given to the resident and/or resident representative. C. Record review of R #6's medical record revealed staff did not complete a Braden assessment (assessment tool used to determine the resident's risk of pressure ulcer development). D. Record review of R #6's Wound Evaluation, dated 11/13/24, revealed the following: - Pressure ulcer, Stage 1. - Location: Right lateral heel. - Present on Admission. - Measurements: Length 7.6 cm, width 2.8 cm, depth not documented, area 6.67 cm^2. - Staged by facility nurse. - Boggy with no open areas. - Surrounding tissue dry and flaky. - Treatment: Generic wound cleanser. No dressing. Foam mattress, heel suspension/protection device, repositioning program. - Healable. - Notification: None documented. - Electronically signed by the Nurse. E. Record review of R #6's Wound Evaluation, dated 11/13/24, revealed the following: - Pressure ulcer, Stage 4. - Location: Right medial malleolus (ankle.) - Present on Admission. - Measurements: Length 1.15 cm, width 0.58 cm, depth not documented, area 0.51 cm^2. - Staged by facility nurse. - Granulation present 50%, Sough Present 0%, Eschar present 0%. - Evidence of infection: Redness, inflammation. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Light, serous exudate. - Edges attached, surrounding tissue with erythema, induration less than 2 cm around the wound, no swelling or edema. - Treatment: Foam mattress, heel suspension/protection device, and repositioning program. - Healable. - Notification: None documented. - Electronically signed by the Nurse. F. Record review of R #6's Wound Evaluation, dated 11/13/24, revealed the following: - Pressure ulcer, Stage 1. - Location: Left heel. - Present on admission. - Measurements: Length 1.55 cm, width 1.13 cm, depth not documented, area 1.32 cm^2. - Staged by facility nurse. - Wound bed: Boggy, intact skin. - Surrounding tissue: Dry, flaky, intact. - Treatment: Generic wound cleanser, foam mattress, heel suspension/protection device, repositioning program. - Healable. - Notification: None documented. - Electronically signed by the Nurse. G. Record review of R #6's Physician Orders, dated November 2024, revealed the following: - Order dated 11/13/24, pressure redistribution cushion to chair. - Order dated 11/13/24, pressure redistribution mattress to bed. - The record did not contain any treatment orders for the resident's right lateral heel pressure ulcer, right medial ankle pressure ulcer, left heel pressure ulcer, and left ankle pressure ulcer. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	H. Record review of R #6's Medication Administration Record (MAR) and Treatment Administration Record (TAR), dated November 2024, the record did not contain the following wound care orders or documentation staff administered the orders: - Stage 1 pressure ulcer to right heel. Orders dated 11/13/24. - Unstageable pressure ulcer to left heel. Orders dated 11/13/24. I. Record review of R #6's Doctor's Progress Note, dated 11/14/24, revealed the following: - Initial history and physical visit to establish care, review the medical chart, reconcile medications, assess medical problems, initiate treatment plans, and discuss treatment with resident and staff. - Conferred with nursing staff. No acute concerns, complaints, or issues were brought forth at the time. - Skin: Warm, dry. - Wound: None. - Diagnoses did not include the resident's pressure ulcers. - Continue facility skin break down prevention protocol. - Full chart reviewed since last seen. - The Doctor did not document the resident's pressure ulcers or skin tear. - The Doctor did not document any treatment orders for the resident's pressure ulcers or skin tear. - Electronically signed by the Doctor. J. Record review of R #6's Nurse Assessment, dated 11/15/24, revealed the following: - Skin warm and dry. Skin color within normal limits. Turgor (relates to skin elasticity, the ability of skin to restore its shape after being pinched) is normal. - Special care: The nurse did not document any information. - The nurse did not document the resident's pressure ulcers or skin tear. - Electronically signed by the LPN. K. Record review of R #6's Doctor's Progress Note, dated 11/15/24, revealed the following: - Acute follow-up visit. Follow-up on admitting medical complaints, to include leg redness. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Examined both lower extremities and there was not any sign of infection, redness, pain, vascular change, or other symptoms concerning. Resident had a dressing in place which was clean, dry, and intact. It was not removed at time of encounter. Resident denied complaint. Spoke with nursing staff and other concerns were not noted. - Skin warm and dry. - Diagnoses did not include the resident's pressure ulcers. - The Nurse Practitioner (NP) did not document the resident's pressure wound treatments. - Electronically signed by the NP. L. Record review of R #6's Wound Evaluation, dated 11/28/24, revealed the following: - Unstageable pressure ulcer. (Documentation dated 11/13/24 showed this was a Stage 1 pressure ulcer.) - Location: Right lateral heel. - Present on admission. - Measurements: Length 1.18 cm, width 0.77 cm, depth 0.1 cm, area 0.66 cm^2. - Staged by in-house nursing. - Wound bed: Epithelial tissue. - Edges attached, surrounding tissue erythema (redness.) - Treatment: Generic wound cleanser, skin prep. - Healable. - Progress: Stalled. - Notification: None documented. - Electronically signed by the SHTL. M. Record review of R #6's Wound Evaluation, dated 11/28/24, revealed the following: - Stage 4 pressure ulcer. - Location: Right medial ankle. - Present on Admission. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Measurements: length 1.11 cm, width 0.66 cm, depth 0.1 cm, area 0.55 cm^2. - Wound bed: Epithelial and granulation. - Moderate serosanguineous exudate. - Surrounding tissue erythema. - Low pain with dressing. - Treatment: Generic wound cleanser, composite dressing, Medihoney. - Healable. - Stable. - Notification: None documented. - Electronically signed by the SHTL. N. Record review of R #6's Wound Evaluation, dated 11/28/24, revealed the following: - Unstageable pressure ulcer. (Documentation dated 11/13/24 showed this was a Stage 1 pressure ulcer.) - Location: Left heel. - Minutes old and acquired in-house. (Pictures and documentation dated 11/13/24 showed this wound was present on admission.) - Measurements: length 0.8 cm, width 0.62 cm, depth not documented, area 0.27 cm^2. - Staged by in-house nursing. - Wound bed: Epithelial tissue. - Edges attached, surrounding tissue erythema (redness.) - Treatment: Generic wound cleanser, skin prep. - Healable. - Notification: None documented. - Electronically signed by the SHTL. O. Record review of R #6's Wound Evaluation, dated 11/28/24, revealed the following: (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Stage 1 pressure ulcer. - Location: Rear left ankle. - Present on admission. (Pictures and documentation dated 11/13/24 showed this wound was not present on admission.) - Measurements: length 0.59 cm, width 0.33 cm, depth 0.1 cm, area 0.14 cm^2. - Staged by in-house nursing. - Wound bed: Epithelial tissue. - Edges attached, surrounding tissue normal in color. - Treatment: Skin prep. - Healable. - Improving. - Notification: None documented. - Electronically signed by the SHTL. P. Record review of R #6's Medication Administration Record (MAR) and Treatment Administration Record (TAR), dated November 2024, the record did not contain the following wound care orders or documentation staff administered the orders: - Stage 1 pressure ulcer to right heel. Orders dated 11/28/24. - Stage 1 pressure ulcer to left ankle. Orders dated 11/28/25. Q. Record review of R #6's medical record revealed the following: - The record did not contain any documentation staff administered the following wound treatments: - Stage 1 pressure ulcer to right heel. Orders dated 11/13/24 and 11/28/24. - Unstageable pressure ulcer (Stage 1) to left heel. Orders dated 11/13/24 and 11/28/24. - Stage 1 pressure ulcer to left ankle. Orders dated 11/28/25. - The record did not contain documentation staff notified the resident's doctor of the new pressure wound on the resident's ankle. R. Record review of R #6's care plan revealed the following: (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Dated 11/13/24, updated 11/19/24. - The resident was at risk for skin breakdown related to advanced age, decreased activity, frail fragile skin, and limited mobility. - The resident would not show signs of skin breakdown for 90 days. - Interventions: Pressure redistribution surface to chair and bed, weekly skin check by licensed nurse, offload heels while in bed, observe skin condition daily with ADL care and report abnormalities, apply barrier cream with each cleansing. - The record did not document the resident's pressure ulcers to her heels and ankles. S. Record review of R #6's Nursing Skilled Evaluation, dated 11/29/24, revealed the following: - Pain: Indicators of pain: None. - The record did not contain any information in the following areas: skin, special care, safety, completed clinical suggestions, comments. - The record did not address the resident's pressure wounds on her ankles and heels and her wound treatments. - Electronically signed by an agency licensed nurse. T. Record review of R #6's Progress Note, dated 12/02/25, revealed the following: - Visit type was acute follow-up. - Chief complaint and nature of the presenting problem: Follow-up of admitting medical diagnoses, including depression. - Resident was a fairly inconsistent historian but at time of encounter denied complaint or concern. - Nursing staff denied new or worsening behaviors, recent fall or injury, unstable vital signs, or other complaint or concern. - The record did not address the resident's pressure wounds on her ankles and heels and her wound treatments. - Electronically signed by the Nurse Practitioner on 12/03/24 at 4:55 pm. U. Record review of R #6's nutrition progress note, dated 12/03/24, revealed the following: - Resident had multiple wounds: Unstageable pressure wound to left heel, Stage 1 pressure wound to left ankle improving, unstageable pressure to right lateral heel stalled, and Stage 4 pressure wound to right medial ankle. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	V. Record review of R #6's Wound Evaluation, dated 12/04/24, revealed the following: - Unstageable pressure ulcer. (Documentation dated 11/13/24 showed this was a Stage 1 pressure ulcer.) - Location: Right lateral heel. - Present on admission. - Measurements: Length 4.18 cm, width 1.53 cm, depth 0.1 cm, area 2.06 cm^2. - Staged by in-house nursing. - Wound bed: Epithelial tissue. - Edges attached, surrounding tissue erythema (redness.) - Treatment: Generic wound cleanser, skin prep. - Healable. - Progress: Stable - Notification: None documented. - Electronically signed by the SHTL. X. Record review of R #6's Wound Evaluation, dated 12/04/24, revealed the following: - Stage 4 pressure ulcer. - Location: Right medial ankle. - Present on Admission. - Measurements: length 1.28 cm, width 0.97 cm, depth 0.1 cm, area 0.88 cm^2. - Wound bed: Epithelial. - Edges attached, surrounding tissue erythema (redness.) - Treatment: Generic wound cleanser, skin prep. - Healable. - Stable. - Notification: None documented. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Electronically signed by the SHTL. Y. Record review of R #6's Wound Evaluation, dated 12/04/24, revealed the following: - Unstageable pressure ulcer. (Documentation dated 11/13/24 showed this was a Stage 1 pressure ulcer.) - Location: Left heel. - Acquired in-house. (Pictures and documentation dated 11/13/24 showed this wound was present on admission.) - Measurements: Length 1.13 cm, width 0.95 cm, depth 0.1 cm, area 0.71 cm^2. - Staged by in-house nursing. - Wound bed: Epithelial tissue. - Edges attached. - Treatment: Generic wound cleanser, skin prep. - Healable. - Notification: None documented. - Electronically signed by the SHTL. Z. Record review of R #6's Wound Evaluation, dated 12/04/24, revealed the following: - Stage 1 pressure ulcer. - Location: Rear left ankle. - Present on admission. (Pictures and documentation dated 11/13/24 showed this wound was not present on admission.) - Measurements: length 0.58 cm, width 0.39 cm, depth 0.1 cm, area 0.15 cm^2. - Staged by in-house nursing. - Wound bed: Epithelial tissue. - Edges attached. - Treatment: Generic wound cleanser, skin prep. - Healable. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Improving. - Notification: None documented. - Electronically signed by the SHTL. AA. Record review of R #6's Physician Orders, dated December 2024, revealed the following: - Order dated 12/04/24, for right heel wound. Clean with generic wound cleanser every day and night shift. Pat dry and apply skin prep. Leave open to air. - Order dated 12/04/24, for right ankle wound. Clean with generic wound cleanser every day and night shift. Pat dry and apply skin prep. Leave open to air. - Order dated 12/04/24, for left heel wound. Clean with generic wound cleanser every day and night shift. Pat dry and apply skin prep. Leave open to air. - Order dated 12/04/24, for left ankle wound. Clean with generic wound cleanser every day and night shift. Pat dry and apply skin prep. Leave open to air. BB. Record review of R #6's MAR and TAR, dated December 2024, revealed the following: - The record did not contain the following wound care orders or documentation staff administered the orders: - Stage 1 pressure ulcer to right heel. Orders dated 12/04/24. - Unstageable pressure ulcer (Stage 1) to left heel. Orders dated 12/04/24. - Stage 1 pressure ulcer to left ankle. Orders dated 12/04/24. CC. Record review of R #6's medical record revealed it did not contain any documentation staff administered the following wound treatments: - Stage 1 pressure ulcer to right heel. Orders dated 12/04/24. - Unstageable pressure ulcer (Stage 1) to left heel. Orders dated 12/04/24. - Stage 1 pressure ulcer to left ankle. Orders dated 12/04/24. DD. Record review of R #6's Nursing Skilled Evaluation, dated 12/07/24, revealed the following: - Pain: Indicators of pain: None. - The record did not contain any information in the following areas: skin, special care, safety, completed clinical suggestions, comments. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- The record did not address the resident's pressure wounds on her ankles and heels and her wound treatments. - Electronically signed by an agency licensed nurse. EE. On 03/06/25 at 1:27 pm and 03/07/25 at 1:45 pm, during a record review and interview, the Skin Health Team Lead (SHTL) stated she began working at the facility on 11/18/24. She stated she was in training at that time. She stated she began working immediately as the SHTL. The SHTL stated her job duties included seeing residents with wounds once weekly and entering treatments into the resident's record. She stated the facility nurses provided the resident's treatments on the days in between her visits. The SHTL stated she came into the facility on her day off, 11/27/24, to take pictures of resident wounds and complete audits. She stated the facility's previous SHTL stopped working at the facility months before she began employment, and the Unit Managers were doing the resident skin assessments. The SHTL stated she was familiar with R #6, and she met the resident on her first day at the facility. The SHTL stated she assessed the resident's wounds and entered the treatments into the resident's record. She stated the nurses were supposed to continue the treatment in between her weekly skin assessments. The SHTL stated the nurses did not continue the treatment, because the order did not go into R #6's MAR/TAR. The SHTL stated there was a drop down box in the program, and she chose auxiliary in the drop down. She stated she was not aware she should have chosen TAR in order for the order to carry over to R #6's TAR. The SHTL stated the nurses referred to the resident's TAR in order to provide treatment for wounds in between her visits. She stated since the treatment was not transferred, there was not any evidence that staff completed R #6's wound treatments. FF. On 03/07/25 at 4:01 pm, during an interview with the Administrator (ADM) and the Director of Nursing (DON), the DON stated she began her position on 12/24/24, and the Administrator stated he began his position 11 months ago. The DON stated the SHTL received training from the SHTL at a sister facility, she trained with the Corporate SHTL, and she had health stream trainings she completed. The DON stated the SHTL received training at hire and quarterly. She stated the SHTL received training on how to enter the residents' treatment orders during clinicals. The DON and the Administrator stated the SHTL was responsible to oversee the residents' wounds, take pictures of the wounds, conduct skin and wound evaluations, enter wound care orders, and oversee the interventions for potential or actual issues. They stated the SHTL evaluated the residents on admission, weekly thereafter, and as needed. The DON stated the facility nurses were responsible to provide wound care in between the SHTL visits and to document the treatment administration in the residents' records. The DON stated the wound care orders should be on the resident's TAR, and the nurses should sign off that the treatment was administered. The DON stated if there was not any documentation in the resident's MAR/TAR, then she would question the staff. She stated she reviewed the MAR/TAR when she had a concern, and she did not have a set schedule. The DON stated she was not at the facility while R #6 was a resident, but the Administrator was. The Administrator stated he was present while R #6 was at the facility, and he spoke to the resident several times. The DON stated staff did not complete Braden assessments at the time she began (12/24/24), and that was why R #6 did not have a Braden assessment in her record. The Administrator stated staff did not complete R #6's Braden assessment.

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

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F 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure the resident's doctor reviews the resident's care, writes, signs and dates progress notes and orders, at each required visit. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39509 Extended Survey Based on record review and interview, the facility failed to ensure residents had a written, signed, and dated progress note from their physician after each visit for 8 (R #'s 8, 9, 10, 11, 12, 13, 14, 15) of 8 (R #'s 8, 9, 10, 11, 12, 13, 14, 15) residents reviewed for current physician progress notes and documentation. This deficient practice is likely to result in resident's records being incomplete and resident care not being documented and reviewed. The findings are: R #16 A. Record review of R #8 face sheet dated 04/09/25 revealed she was admitted to the facility on [DATE] with multiple diagnoses including: -Acute and Chronic Respiratory Failure. -Chronic Kidney Disease. -Difficulty walking. The face sheet also revealed that primary care provider (PCP) was a doctor of a senior service agency, not a provider connected to the facility. B. Record review of R #8 electronic medical record (EMR) for the past six months revealed there were no progress notes that had been submitted by the PCP or the PCP's agency for any visits. R #17 C. Record review R #9 face sheet dated 04/09/25 revealed she was admitted to the facility on [DATE] with multiple diagnoses including: -Encephalopathy (Any disease that alters brain function or activity). -Acute and Chronic Respiratory Failure. -Dementia (a chronic progressive disease that causes loss of memory and thought) The face sheet also revealed that primary care provider (PCP) was a doctor of a senior service agency, not a provider connected to the facility. D. Record review of R #9 electronic medical record (EMR) for the past six months revealed there were no progress notes that had been submitted by the PCP or the PCP's agency for any visits. R #10 (continued on next page)

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F 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	E. Record review of R #10 face sheet dated 04/01/25 revealed she was admitted to the facility on [DATE] with multiple diagnoses including: -Cerebral (brain) Infarction (death of tissue due to lack of oxygen-stroke) -Acute Kidney Failure -Alzheimer's Disease (a chronic progressive disease that causes loss of memory and thought) The face sheet also revealed that primary care provider (PCP) was a doctor of a senior service agency, not a provider connected to the facility. F. Record review of R #10 electronic medical record (EMR) for the past six months revealed there were no progress notes that had been submitted by the PCP or the PCP's agency for any visits. R #11 G. Record review of R #11 face sheet dated 04/09/25 revealed she was admitted to the facility on [DATE] with multiple diagnoses including: -Fracture (break) of left lower leg -Alzheimer's Disease -Chronic Kidney Disease The face sheet also revealed that primary care provider (PCP) was a doctor of a senior service agency, not a provider connected to the facility. H. Record review of R #11 electronic medical record (EMR) for the past six months revealed there were no progress notes that had been submitted by the PCP or the PCP's agency for any visits. R #12 I. Record review of R #12 face sheet dated 04/02/25 revealed he was admitted to the facility on [DATE] with multiple diagnoses including: -Fracture of right Femur (upper leg bone) -End Stage Renal (Kidney) Disease -Dependence on Renal Dialysis (a mechanical process of cleansing blood) The face sheet also revealed that primary care provider (PCP) was a doctor of a senior service agency, not a provider connected to the facility. J. Record review of R #12 electronic medical record (EMR) for the past six months revealed there were no progress notes that had been submitted by the PCP or the PCP's agency for any visits. (continued on next page)

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F 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R #13 K. Record review of R #13 face sheet dated 04/02/25 revealed she was admitted to the facility on [DATE] with multiple diagnoses including: -Fracture of Right Femur -Heart Failure -Dementia The face sheet also revealed that primary care provider (PCP) was a doctor of a senior service agency, not a provider connected to the facility. L. Record review of R #13 electronic medical record (EMR) for the past six months revealed there were no progress notes that had been submitted by the PCP or the PCP's agency for any visits. R #14 M. Record review of R #14 face sheet dated 04/09/25 revealed she was admitted to the facility on [DATE] with multiple diagnoses including: -Encephalopathy -Muscle Weakness -Acute Respiratory (breathing) Failure -Pneumonia (a bacterial infection of the lungs)The face sheet also revealed that primary care provider (PCP) was a doctor of a senior service agency, not a provider connected to the facility. N. Record review of R #14 electronic medical record (EMR) for the past six months revealed there were no progress notes that had been submitted by the PCP or the PCP's agency for any visits. R #15 O. Record review of R #15 face sheet revealed she was admitted to the facility on [DATE] with multiple diagnoses including: -Cardiomegaly (enlarged heart) -Bipolar (a psychiatric condition characterized by changes in mood and affect) Disorder -Obsessive-Compulsive (a psychiatric condition characterized by repetitive behaviors and motion) Disorder The face sheet also revealed that primary care provider (PCP) was a doctor of a senior service agency, not a provider connected to the facility. (continued on next page)

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F 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	P. Record review of R #15 electronic medical record (EMR) for the past six months revealed there were no progress notes that had been submitted by the PCP or the PCP's agency for any visits. Q. On 04/02/25 at 12:00 pm during interview with the facility Director of Nursing (DON), she reported that the facility had a total of 8 residents who's care was managed by a senior service agency. She identified these residents as R #8-15. She stated the agency had an assigned PCP and other providers who would come to the facility and conduct in person visits with the 8 residents. She also stated that this senior service transported some of these 8 residents from the facility to their own agency clinic where they were also visited by their PCP. She stated these visits occurred frequently-and estimated each resident was seen by a PCP weekly. R. On 04/03/25 at 11:00 am during interview with DON, she stated that the senior agency seldom provided written, signed, dated progress notes of these visits. She reviewed the resident records and confirmed that there were very few progress notes in the EMR for any of the possible visits.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39509 PAST NON-COMPLIANCE Based on record review and interview, the facility failed to ensure medications were monitored and administered as ordered for 1 (R #s 16) of 1 (R #s 16) resident reviewed for medications not given as ordered by the physician. This deficient practice can result in a resident receiving an excessive dose of the medications that could cause harm and possible death. The findings are: A. Record Review of R #16 face sheet dated 04/01/25 revealed she was admitted to the facility on [DATE] with multiple diagnoses including: -Parkinson's (a chronic, progressive disease of the nervous system) Disease -Age-Related Physical Debility (age related decline of physical function) B. Record review of R #16 provider orders revealed the following orders: -03/10/25 Morphine Sulfate (a narcotic pain relieving medication) 20 mg (milligrams) per 5 ml (milliliter) oral (by mouth) solution. Give 1.3 ml every 4 hours for pain. -03/10/25 Morphine Sulfate 20mg/5ml oral solution. give 1.3 ml every two hours as needed for pain. -03/13/25 Morphine Sulfate 20mg/5ml oral solution. Give 1.3 ml every hour for pain. C. Record review of R #16 Medication Administration Record (MAR) dated March 2025 revealed the following administrations: Morphine Sulfate 20mg/5ml give 1.3 ml every 4 hours. -03/10/25 given at 6:00 pm and 10:00 pm. -03/11/25 given at 2:00 am, 6:00 am, 10:00 am, 2:00 pm, 6:00 pm and 10:00 pm. -03/12/25 given at 2:00 am, 6:00 am, 10:00 am, 2:00 pm, 6:00 pm and 10:00 pm. -03/13/25 given at 2:00 am, 6:00 am, 10:00 am, 2:00 pm, and 6:00 pm. Morphine Sulfate 20mg/5ml give 1.3 ml every 2 hours as needed -03/13/25 given at 7:30 am Morphine Sulfate 20mg/5ml give 1.3 ml every hour. -03/13/25 at 7:00 pm, 8:00 pm, 9:00 pm, 10:00 pm, 11:00 pm (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-03/14/25 administered every hour as ordered. D. Record review of daily care notes revealed the following: -03/15/25 at 12:05 am a nursing note that identified a medication error. The note stated that a pharmacist from the pharmacy service had called the nurse to clarify the Morphine order. The pharmacist told the nurse that the wrong dose had been sent and that the medication sent was Morphine 20 mg/1 ml. The note further stated that the pharmacy and the facility staff failed to verify that the medication sent matched the medication order and that a total of 47 doses of the wrong medication had been administered before the error had been discovered. Vital signs of R #16 were stated as blood pressure 80/51 (normal is 120/80), O2 (blood oxygen level-a measure of the oxygen in the blood) 61% (normal is 90% or greater) pulse (heart rate) 101 (normal is 76). The on-call provider and facility nursing managers were notified of the error. -03/15/25 at 12:11 am a nursing note that Morphine Sulfate was being held per direction of the on call provider until the correct dose can be received. -03/15/25 at 1:58 am stated correct Morphine dose received and resumed administration per provider orders. -03/15/25 at 2:03 am a nursing note that family was notified of the medication error and correction and that the corrected dose of 5.2 mg was being administered instead of the 26 mg that had been administered. E. On 04/01/25 at 2:00 pm during phone interview with R #16's son, he stated that his mother was admitted to the facility for end of life care. He stated after his mother's admission to the facility the nurses began to administer Morphine to manage her pain. He stated as the days passed, his mother began to decline-her breathing became shallow, her oxygen levels began to drop, she became slow to respond and slept almost constantly. He stated the nursing staff and provider all told him and his family his mother was at end of life and she was expected to die within hours. He stated that when the medication error was discovered and the dose changed, she became more alert and responsive. F. On 04/02/25 at 10:00 am during interview with the Director of Nursing (DON) she stated that R #16 had been admitted to receive end of life care. DON stated that the provider ordered Morphine 20 mg/5 ml was to be administered per provider ordered schedule. She stated the pharmacy sent the wrong dose of 20 mg/1 ml. She stated this was not discovered until 03/15/25. DON confirmed that the medication should have been checked by the nurse receiving the medication to confirm that it was the right dose per the provider order. She further confirmed that with the administration of each dose after, the nurse administering the medication should have checked to assure that the medication and dose being administered was the medication and dose that was ordered. DON further stated that beginning on the morning of 03/15/25, staff were reeducated as to the proper administration of all resident medications to assure that all nurses checked that all medications were the right dose and medication as ordered. DON also stated that the facility reviewed all resident medications and found there were no other medication errors. DON provided copies of all trainings and audits of medications and medication administrations and stated that all nursing staff who passed medications had been educated as to monitoring and recognizing errors. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	G. On 04/03/25 at 11:30 am during interview with Registered Nurse (RN) #1 and Licensed Practical Nurse (LPN) #1, both stated they had been made aware of a medication error and that each had been educated to check resident medications dose, time and person with each administration.

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F 0812 Level of Harm - Potential for minimal harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 33768 Based upon observation and interview, the facility failed to ensure that food was prepared and served to prevent cross contamination when kitchen aides were not wearing hairnets during the lunch meal services. This deficient practice could likely affect all residents identified on the facility census provided by the Administrator on 02/14/25. The findings are: A. On 02/15/25 at 12:12 pm, during lunch meal service, staff were standing in the doorway of the kitchen, waiting to be handed lunch meal trays to be passed out to residents sitting in the dining room. Upon observation, there was an unidentified staff member inside the kitchen and not wearing a hairnet. Near the kitchen entrance, there were no hairnets available. Surveyor requested a hairnet for the Dietary Manager (DM) and the DM went to the back of the kitchen and returned with a hairnet. B. On 02/15/25 at 12:16 pm during observation. Kitchen Aide (KA) #1, KA #2 and KA #3 and were observed preparing the lunch meal service in the facility kitchen by being handed plates with served food, and they placed food items and plate lids on the plates and then placed plates on a meal tray. KA #1-3 were not wearing hairnets. C. On 12/15/25 at 12: 23 pm during observation, KA #1 was now wearing a hairnet. Interview with the District Manager confirmed that kitchen staff should be wearing hairnets when preparing and serving food.

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Administer the facility in a manner that enables it to use its resources effectively and efficiently. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39509 Based on record review and interview, the facility administration failed to ensure a system of receiving timely response from the provider for 8 (R's #8, #9, #10, #11, #12, #13, #14, #15, #16, #17, #18) of 8 (R's #8, #9, #10, #11, #12, #13, #14, #15, #16, #17, #18) residents reviewed for physician communications. This deficient practice is likely to result in residents not receiving optimal care and the facility not have knowledge of physician plans and directives. Cross reference to F684 and F711 for further information A. Record review of R #8-15 revealed that each resident was being provided medical care through a senior service provider. B. On 04/02/25 at 12:10 pm during interview with the Director of Nursing (DON), stated that R #10 is one of several residents who are managed by a PCP who is not connected with the facility. She stated that the facility nurses must call this service for orders. DON stated that there have been times when the staff reported to her that the PCP from this service failed to respond to requests for directions and orders from the PCP. She stated there have been times that she has been contacted by staff and then she had to call the PCP on their personal cell phone to get directions and orders for resident care. She further stated that the PCP has failed to enter orders for medication changes or new medications causing delay of care for residents. She stated this is what happened with R #10 in November and December of 2024. DON further stated that the senior service PCP's don't provide results of visits, results of diagnostic tests or medical plans. C. On 04/01/25 at 4:40 pm during interview with Licensed Practical Nurse (LPN) #2, she stated that she had had to call the PCP for R #10 and other residents who receive care from the same PCP. LPN #2 stated that on weekdays the PCP will usually respond within 20 -30 minutes to phone calls to discuss resident changes. LPN #2 stated that on weekends she has called this PCP and did not receive a call back for 12 to 24 hours. LPN #2 stated this was not unusual but could not recall specific dates, times or residents. D. On 04/01/25 at 4:50 pm during interview with LPN #3, she stated that she has had to call the PCP for R #10 and other residents who receive care from the same PCP. LPN #3 stated that she has had many occasions when she has called the PCP and left a message. She stated the PCP would respond back but there were times when she had to wait for 2-3 hours. LPN #3 stated this had not happened recently. She could recall an instance in December 2024 or January 2025 when this happened but could not recall the resident or specifics of the call. E. On 04/02/25 at 12:30 pm during phone interview with the facility Medical Director (MD) she stated that she is the MD for multiple facilities. She stated she is aware of R #10's PCP. She stated the PCP is part of a senior (persons over [AGE] years of age) service that provides care to a large number of seniors in the area. MD stated that she has had several instances where she has contacted and discussed with the PCP to be available and respond to nursing staff calls. She stated the service and their PCP's continue to be slow to respond. MD stated this has been discussed with the facility administrator in the past. (continued on next page)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	F. On 04/03/25 at 1:30 pm during interview with the facility administrator (ADM) he stated that he was aware of R #10's PCP and the senior service. He stated that the facility had other residents who were managed by the same senior service. ADM stated that he had been told on several occasions of residents whose care had been delayed because of the PCP's failure to respond to the calls of facility nurses. ADM confirmed that the facility should be requiring the senior service and PCP's to provide information about resident care, medical plans and test results. ADM stated that he had met with staff from the senior service on 04/02/25 to discuss this and other issues.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38450 Based on observations, interviews, and record reviews, the facility failed to utilize enhanced barrier precautions (an infection control intervention) when performing wound care to 2 (R #4, #5) out of 2 (R #4, #5) residents. Failure to utilize enhanced barrier precautions when performing wound care has the potential to expose the residents to multidrug resistant organisms. The findings are: A. Review of Centers for Medicare and Medicaid Services' (CMS') Enhanced Barrier Precautions in Nursing Homes to Prevent Spread of Multidrug-resistant Organisms (MDROs), dated 03/20/24, revealed the following: - MDRO transmission is common in long term care (LTC) facilities. - Enhance Barrier Precautions (EBP) refer to an infection control intervention designed to reduce transmission of MDRO that employs targeted gown and glove use during high contact resident care activities. - EBP are indicated for residents with wounds, even if the resident is not known to be infected or colonized with a MDRO. B. Record review of R #4's medical record revealed the following: - admitted [DATE]. - Stage 3 pressure ulcer (full thickness skin loss that extends into deeper tissue and fat but not into muscle, tendon, or bone) to right heel. - Treatment order, dated 12/25/24, for right heel. Cleanse with Vashe (wound cleanser) solution, pat dry, place calcium alginate and apply Optifoam bordered gauze (wound dressing.) Cover with elastic tubular bandage. C. On 03/06/25 at 1:27 pm, during an observation of wound care, the Skin Health Team Lead (SHTL) provided wound care to R #4. The SHTL used hand sanitizer and donned (put on) gloves, but the SHTL did not don a gown before providing wound care to the resident's heel. D. Record review of R #5's medical record revealed the following: - admitted [DATE]. - Arterial wound (caused by decreased blood circulation) to left ankle amputation site. - Treatment order, dated 03/05/25, for left ankle amputation site. Cleanse wound with Vashe. Pat dry. Apply hydrogel cover (wound dressing designed to provide a moist environment for wound healing) with collagen pad (wound dressing made from collagen to stimulate new tissue growth.) Cover with ABD pad (large wound dressing) and kerlix (bandage roll.) (continued on next page)

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Diabetic wound to right dorsum (upper surface) toe. - Treatment order, dated 02/15/25, for right dorsum toe. Cleanse wound with Vashe. Pat dry. Apply betadine. Cover with bandaid. E. On 03/06/25 at 2:40 pm, during an observation of wound care, the SHTL provided wound care to R #5. The SHTL used hand sanitizer and donned gloves, but the SHTL did not don a gown before providing wound care to the resident's leg and toe. F. On 04/04/25 at 10:30 am during an interview with the Director of Nursing (DON) and the Infection Control Coordinator, the Infection Control Coordinator stated the facility had a list of targeted concerns that required EBP, which included open wounds. She stated staff were to use a gown and gloves whenever they entered the room of a resident with open wounds. She stated staff have been trained to EBP procedures, and they make random observations to monitor if staff follow the policy. She stated staff are re-educated if they observe the staff not following EBP.