STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	325036	A. Building B. Wing	06/03/2025

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview the facility failed to safeguard clinical record information by leaving Private Health Information (PHI) where unauthorized persons had access to it for the residents of Unit 1 and Unit 2 during random observations. If the resident's clinical information is not sufficiently safe guarded, resident's PHI is likely to be viewed by unauthorized residents, visitors, and staff. The findings are: A. On 06/02/25 at 8:50 AM, during a routine observation of Unit 1 nurses' station, a vital sign sheet was face-up on the counter, displayed the vital signs and names of all the residents in Unit 1. This information was visible to any unauthorized persons approaching the nurses' station. B. On 06/02/25 at 8:53 AM, during an interview with Licensed Practical Nurse (LPN) #1, he confirmed that the vital sign sheet had been left face-up on the counter, making the information visible to all. He stated that it should have been placed face-down. C. On 06/02/25 at 9:17 AM, during a routine observation of Unit 2 nurses' station, a daily resident census sheet was face-up on the counter, displaying the names and room numbers of all residents in the facility. This information was visible to any unauthorized persons approaching the nurses' station. D. On 06/02/25 at 9:19 AM, during an interview with LPN #2, she confirmed that the daily census sheet had been left face-up on the counter, making it visible to all. She stated that it should not have been left face-down. E. On 06/02/25 at 9:23 AM, during a routine observation of Unit 1, a weight list containing the weights of all residents in the facility was found on a clipboard hanging outside room [ROOM NUMBER], facing outward, where it was visible to anyone passing by. F. On 06/02/25 at 9:25 AM, during an interview with LPN #1, he confirmed that the weight list sheet had been left hanging facing outward and should not have been.

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 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** Based on record review and interview, the facility failed to provide care that met professional standards for 1 (R #2) of 1 (R #2) resident when medications were administered which were contraindicated (medications that counteract each other) resulting in the resident experiencing diarrhea (a condition characterized by excessive and loose, watery bowel movements). This deficient practice is likely to result in residents being uncomfortable, developing skin damage and becoming dehydrated (a condition where the body loses more fluids than it takes in). The findings are: A. Record review of R #2 face sheet dated 06/05/25 revealed he was admitted to the facility on [DATE] with the following diagnoses: -Aneurysm (a weak spot of the wall of an artery) of Iliac Artery (a major artery in the lower body that supplies oxygenated blood to the lower limbs). -Hemiplegia (paralysis or severe weakness of one side of the body) Left side B. Record review of R #2's provider orders revealed the following medication orders: -Started 04/01/25, Sennosides-Docusate (medication prescribed to treat and reduce constipation (infrequent and hard to pass bowel movements) 8.6 -50 MG (milligrams) give 1 tablet twice daily for constipation. Discontinued and replaced on 06/04/25 to give 1 tablet every 12 hours as needed for constipation. -Started 04/25/25 Loperamide (medication prescribed to treat and reduce diarrhea) 2 MG give 1 tablet every 4 hours as needed for diarrhea. -Started 04/01/25 Morphine (narcotic medication that treats pain) 20 mg/ml give 0.25 mil every 4 hours as needed for pain. C. Record review of R #2's Medication Administration Record (MAR) revealed the following medication administrations: Loperamide -05/08/25 Loperamide 1 tablet given at 10:03 am and listed as E (effective). -05/18/25 Loperamide 1 tablet given at 9:57 pm and listed as E. -05/19/25 Loperamide 1 tablet given at 7:29 am and listed as E. -05/22/25 Loperamide 1 tablet given at 5:22 am and listed as I (ineffective). -05/28/25 Loperamide 1 tablet given at 4:35 am and listed as U (ineffective). -05/29/25 Loperamide 1 tablet given at 9:21 am and listed as E. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-05/31/25 Loperamide 1 tablet given at 5:28 am and listed as E. -06/02/25 Loperamide 1 tablet given at 2:18 am. -06/03/25 Loperamide 1 tablet given at 8:29 am. -06/03/25 Loperamide 1 tablet given at 12:36 pm. -Sennoside-Docusate 1 tablet was given at 8:00 am and 8:00 pm on all of the days during the month of May except: 05/09/25 at 8:00 am. D. Record review of R #2's daily care notes revealed the following: -05/18/25 at 10:14 pm nurse note: writer was called to R #2's room because he had diarrhea for the past month. Writer did not know about ongoing diarrhea. The oncall provider was notified and was told to give Loperamide and if no relief contact the PCP (Primary Care Provider). -05/19/25 at 12:30 am On-Call provider note: Assessment-Diarrhea, give Imodium (trade name for Loperamide) and hold Senna (Sennosides-Docusate) for the morning. -05/19/25 at 5:31 am nurse note: Resident (R #2) had two more episodes of diarrhea after medication (Loperamide) was given. Will pass on to oncoming nurse. -05/22/25 at 5:40 am nurse note: resident had two episodes of loose stools this shift Loperamide given. E. On 06/02/25 at 10:30 am during an interview with R #2, he stated, that he feels dirty and smells horrible, he does not want to get out of bed or go out of his room because of his diarrhea. He is not able to control when he goes to the bathroom. He further stated that he needs to be changed several times a day and the staff is not always available to change him and he is left dirty for long periods of time. He has requested that he be showered instead of bed baths because he would feel much cleaner, but they have not honored that request. F. On 06/03/25 at 11:50 am during interview with Certified Nurse Aide (CNA) #1, she stated that she was usually assigned to the unit where R #2 was a resident. She stated she was very familiar with him and his care. She stated that she was aware during her days on the unit that R #2 was complaining of diarrhea almost daily. She stated she had completed brief changes for R #2 several times each day that she had worked. She stated with each brief change, she noted that his bowels were very loose and watery, had a foul smell and was sometimes green in color. She stated she had passed this information on to R #2's assigned nurse with each shift she worked. She stated that from her observations, R #2 was having frequent daily bouts of diarrhea for at least the last two weeks. G. On 06/03/25 at 12:10 pm during interview with Licensed Practical Nurse (LPN #2), she stated that she was the nurse assigned to R #2 today, 06/03/25. She stated that she was also assigned to his care the past two days on 06/01/25 and 06/02/25. She stated she was aware that R #1 has had diarrhea on each of the past two days. She stated she had given him Loperamide today 06/03/25 and yesterday 06/02/25. She stated she had held R #1's morning dose of Sennosides-Docusate each day since 06/01/25. She stated the two medications should not be given together. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	H. On 06/03/25 at 1:00 pm during phone interview with the facility assigned Nurse Practitioner (NP), she stated that common medical practice would be to order the Sennosides-Ducosate daily for a resident who is prescribed narcotic pain medications. She stated that if a resident receiving Sennosides-Ducosate started having diarrhea then common medical practice would be to hold or discontinue the Sennosides-Ducosate and administer Loperamide as needed until the diarrhea ends. She stated that administering both medications at the same time on a daily basis over an extended period of time would be contraindicated as one medication would counteract the other. I. On 06/03/25 at 1:47 pm during interview with Director of Nursing (DON), she reviewed R #2's medical record and his record of medication administration. DON stated that R #2 had an order to administer Sennosides-Ducosate daily. She stated this was a common order for any resident who was receiving narcotic medications to prevent a resident from becoming constipated. She also acknowledged that R #2 had received multiple doses of Loperamide. She stated a resident should not receive both medications at the same time and that a resident who is having diarrhea should not be administered Sennosides-Ducosate at the same time. DON stated that the nurses should have held his Sennosides-Ducosate until the diarrhea had cleared or contacted the provider to notify them of the diarrhea and the contraindicated medications.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, and interview, the facility failed to provide activities of daily living (ADL; activities related to personal care such as bathing, showering, dressing, walking, toileting, and eating) assistance for baths and showers for 1 (R #2) of 1 (R #2) resident reviewed for ADL care. This deficient practice is likely to affect the dignity and health of the residents. The findings are: A. Record review of R #2's face sheet revealed R #2 was admitted into the facility on [DATE]. B. On 06/02/25 at 10:30 AM during an interview with R #2, he stated that he was not receiving showers which he prefers and has requested showers. Instead, he has been given bed baths, and those are inconsistent. He further stated that he had not received a bed bath in about two weeks and that he cannot stand his own stench, which makes him feel like a pig. C. Record review of R #2's care plan dated 10/03/22 revealed, Focus: [Name of R #2] requires assistance for ADL care in bathing, grooming, personal hygiene, dressing, eating, bed mobility, transfer, locomotion, toileting related to CVA (Cerebrovascular accident-medical term for a stroke or brain attack) with limited mobility. Focus: [Name of R #2] is at risk for falls R/T (related to) debility (physical weakness), sedating medications and history of CVA . Interventions: Assistance of two staff members for all transfers. D. Record review of the Shower Schedule revealed R #2 is scheduled to shower on Wednesdays and Saturdays. E. Record review of R #2's Documentation Survey Report (used to chart on resident care) dated April 2025 revealed the report did not contain any documented showers or refusals for the month of April. F. Record review of R #2's Documentation Survey Report dated May 2025 revealed the report did not contain any documented showers or refusals for the month of May. G. Record review of R #2's Shower Sheets revealed R #2 was given four bed baths in the month of May 2025 and for the month of April 2025 shower sheets were not available to review. H. On 06/03/25 at 11:52 AM, during an interview with Certified Nurse Aid (CNA) #1, she stated that hospice is responsible for R #2's showers. She further stated that R #2 had informed her that he would like showers instead of bed baths and she let the floor nurse know of R #2's preference, CNA was unsure of the date she let the floor nurse know. I. On 06/03/25 at 12:09 PM, during an interview with Licensed Practical Nurse (LPN) #2, she stated that she has called hospice multiple times because no one has come here to give R #2 a shower, that is (giving R #2 a shower) part of his hospice care. She further stated facility CNA's will give him a bed bath when hospice does not come in. LPN #2 then confirmed R #2 has not had a shower and I do not know why. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	J. On 06/03/25 at 1:40 PM during an interview with the Director of Nursing (DON), she stated residents should be getting showers if that is their preference and he should be offered showers on the day he is scheduled to have a shower. She further stated that even if hospice is providing showers the facility should still be offering showers to hospice residents.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. Based on observation and interview, the facility failed to serve food at a safe and appetizing temperature for 1 (R #2) of 1(R #2) resident reviewed for food preference. This deficient practice is likely to result in residents consuming less food causing weight loss and malnutrition. The findings are: A. On 06/03/25 during observation of the meal service in the 120 hallway, meal trays arrived at the unit at 12:36 pm for the midday meal service. Meals were on trays that were being held in a tray cart that was closed. Staff began to serve the meals at 12:39 pm. The cart doors were opened and closed as meals were removed from the cart and taken to the assigned room. Each tray removed had a main plate that was covered by a warming cover. All trays were passed out by 12:41 pm. The last tray was held to serve as a test tray. B. On 06/03/25 at 12:44 pm during observation of the the 120 hallway, the Dietary Manager (DM) arrived to the area and he took the test tray from the cart and took the temperatures of the food contained on the test tray. The tray contained a hamburger, broccoli, tater tots (a form of French-fried potatoes), a cookie and several cold drinks. C. On 06/03/25 at 12:45 pm during interview with the DM, he stated that the temperature of the hamburger was 96.8 degrees Fahrenheit and the temperature of the broccoli was measured at 94.7 degrees Fahrenheit. He stated he could not measure the temperature of the tater tots. DM acknowledged that these temperatures were too cool, and the temperatures of the last tray served should be about 130 degrees Fahrenheit. D. On 06/03/25 at 1:00 pm during interview with R #2, she stated that she had just received her meal and that most days her tray arrived with food that was cool to the taste and touch.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation and interview, the facility failed to store and serve food under sanitary conditions when staff failed to ensure: 1. Food items were labeled and dated in the kitchen refrigerator and freezer. 2. Eggs should be refrigerated, kept cold or on ice when out of the refrigerator. 3. Floor in the facility freezer was clean (spilled milk) and free of debris (paper) These deficient practices are likely to affect all 95 residents listed on the resident census list provided by the Administrator on 06/02/25 and are likely lead to foodborne illnesses in residents if food is not being stored properly and safe food handling practices are not adhered to. The findings are: A. On 06/02/25 at 9:15 am during a walk through of the facility's kitchen revealed the following: 1. 2 large serving trays with what appeared to be pieces of cake were unlabeled and undated. 2. 3 bags of whipped topping were undated 3. 1 container of what appeared to be sugar was on the shelf unlabeled and undated 4. Pitcher of juice in the refrigerator was unlabeled and undated 5. A tray of what appeared to be thickened juice was unlabeled and undated in the refrigerator. 6. 1 tray of eggs was out and was not sitting on ice, was under the food warmer then staff removed the tray of eggs and placed back in the refrigerator. (Eggs were warm to the touch) 7. Floor in the freezer had spilled milk and paper and plastic wrappers were on the floor . B. On 06/02/25 at 9:20 am during an interview with the Dietary Manager (DM), he confirmed the findings listed above, and stated foods should be labeled and dated, eggs should be on ice or refrigerated and freezers should be kept free of debris.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on record review and interview, the facility failed to ensure medical records were updated and accurate for 1 (R #2) of 1 (R #2) resident reviewed. If resident medical records are not complete, accurate and up to date, then resident care may be delayed or duplicated. The findings are: A. Record review of R #2's face sheet dated 06/05/25 revealed he was admitted to the facility on on 04/01/25. B. Record review of R #2's provider order dated 04/25/25 stated: give Imodium A-D (a medication that treats diarrhea (a condition of frequent watery stools) 1 tablet by mouth every four hours as needed. C. Record review of R #2's daily medication administration record (MAR) dated June 2025 revealed that on 06/03/25, no Imodium A-D had been given as of 06/03/25 at 12:00 pm when the MAR was reviewed. D. On 06/03/25 at 12:10 pm during interview with Licensed Practical Nurse (LPN) 2, she stated that she had given R #2 a dose of Imodium A-D during the morning medication pass at about 8:00 am. She reviewed the MAR and acknowledged the dose of Imodium A-D had not been documented. She stated she had not documented the administration of the medication because she was very busy and stated she would be documenting the medication as soon as possible. E. On 06/03/25 at 1:45 pm during interview with the Director of Nursing, she stated that all medications should be documented at the time they are given. She stated that nurses are instructed to draw a medication from the cart and administer the medication immediately and to then document the administration of the medication immediately afterward. She stated that there should be no delay between giving and documenting medications.

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure that there was a coordinated plan of care for 1 (R #2) of 1 (R #2) resident reviewed for hospice services. This deficient practice is likely to result in the resident not receiving the services that he needs. The findings are: A. Record review of R #2's admission Minimum Data Set (MDS), dated [DATE], Section O, Special Treatments, Procedures and Programs revealed the resident was on hospice care. B. On 06/02/25 at 12:25 PM during an interview with Hospice Registered Nurse (HRN) #1, he stated that hospice charting is done on a tablet and then printed and given to the facility. He further stated that a hospice binder was brought upon R #2's admission that contained the hospice coordinated plan of care and admitting documentation. C. On 06/03/25 at 8:34 AM during an interview with Licensed Practical Nurse (LPN) #3, she stated that the facility does not have hospice binders, and all hospice documentation is in the Electronic Medical Record (EMR). D. Record review of R #2's EMR revealed that the Coordinated Plan of Care was not present in the Medical Record. E. On 06/03/25 at 1:40 PM during interview, the Director of Nursing confirmed that there was not a coordinated plan of care available for review.