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	07/19/2024

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 18750 Based on record review, observation, interview, and facility policy review, the facility failed to ensure one of two residents (Resident (R)81) out of a total sample of 46 residents observed was cared for in a dignified way by allowing his Foley catheter bag to be viewed from the doorway of his room. This deficient practice had the potential to cause the resident to be treated and cared for in an undignified manner. Findings include: Review of the facility policy titled, Treatment: Considerate and Respectful, revised on 07/01/19, revealed, Policy: Centers will promote respectful and dignified care for patients in a manner and in an environment that promotes maintenance or enhancement of their quality of life while recognizing each patient's individuality. Purpose: To provide patients the rights to a quality of life that supports independent expression, decision making, and respect. 1.9 Demeaning practices: Staff will refrain from practices that are demeaning to patients such as: 1.0.1 Keeping urinary catheter bags uncovered. Review of the Admission Record for R 81 located in the electronic medical record (EMR) under the Profile tab revealed R81 was readmitted to the facility on [DATE]. Review of R81's quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) 06/08/24 located in the EMR under the MDS tab revealed a Brief Interview for Mental Status (BIMS) score of three out of 15, indicating severe cognitive impairment. During an observation on 07/15/24 at 11:00 AM, while walking into R81's room, R81 was lying in bed, and the catheter bag was hanging on the bed with the dark-colored urine in the bag. During an observation on 07/16/24 at 3:00 PM, R81 was lying in bed, and the catheter bag was hanging in view of the doorway. During an interview on 07/17/24 at 12:17 PM, Licensed Practical Nurse (LPN)1 confirmed R81's catheter could be seen from the hallway. LPN1 stated it should be in a privacy bag. LPN1 was asked if it was considered a dignity issue, LPN1 stated, Yes, that is a dignity issue. (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 07/19/24 at 6:36 PM, the Director of Nursing (DON) was asked what the expectation was regarding a catheter bag being in view of anyone passing by the resident's room. The DON stated the catheter bag should have been in a dignity bag.

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 18947 Based on observation, record review, interview, and facility policy review, the facility failed to ensure medications were not being left at the bedside for one of two residents (Resident (R)78) observed who was not assessed to self-administer medications out of 46 sampled residents. This had the potential for the resident not to receive their ordered medications and create unmet care needs. Findings include: Review of the facility's policy titled, Medications: Self-Administration, revised 03/01/22, revealed, Policy: Patients who request to self-administer medications will be evaluated for safe and clinically appropriate capability based on the patient's functionality and health condition. If it is determined that the patient is able to self-administer, A physician/advanced practice provider (APP) order is required. Self-administration and medication self-storage must be care planned. When applicable, patient must be provided with a secure, locked area to maintain medications. Patients must be instructed in self-administration. Evaluation of capability must be performed initially, quarterly, and with any significant change in condition. Self-administration of narcotics, including Schedule 1 Controlled Drugs (e.g., medical marijuana), is not permitted. Medications which require refrigeration are not eligible for bedside storage . Review of R78's Admission Record dated 07/19/24 and found in the Electronic Medical Record (EMR) under the Admissions indicated the resident was admitted to the facility on [DATE] with diagnoses including Chronic Obstructive Pulmonary Disease (COPD). Review of R78's significant change Minimum Data Set (MDS) with an Assessment Reference (ARD) date of 06/11/24, found in the EMR under the MDS tab, indicated a Brief Interview for Mental Status (BIMS) score of 13 out of 15, which indicated the resident was cognitively intact. Review of R78's Order Summary Report dated 01/20/24 and found in the EMR under the Orders did not indicate any orders for the resident to receive any type of MDI (Metered Dose Inhaler) medication or did it indicate any orders for the resident to self-administer her own medication. Review of R78's comprehensive Care Plan, located in the EMR under the Care Plan tab was reviewed and indicated no Care Plan related to the resident self-administering her own medications. There was no evidence in R78's EMR to show an assessment was completed to determine the resident was able to self-administer her own medication. During an observation on 07/18/24 at 8:25 AM, R78 was observed dozing off in her bed. A medication cup with six unidentified pills was sitting on the table next to the resident's bed. There was no nursing staff observed to be in the room with R78. (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 07/18/24 at 8:36 AM, Licensed Practical Nurse (LPN)1 approached the surveyor with a cup of unidentified pills and stated the pills were sitting on R78's table when she entered the room to administer the resident's morning medications. LPN1 stated the medication must have been left on the resident's table unattended by the night nurse. She stated pills were not supposed to be left unattended with residents. She stated the medications should not be left on the table like that. During an interview with the Unit Manager (UM) on 07/18/24 at 8:38 AM, she stated medication was not to be left unattended at any resident's bedside. She stated no resident in the facility had been assessed to safely self-administer their own medication. She stated nursing was expected to keep all medications in the medication cart. During an interview with the Administrator on 07/19/24 at 5:40 PM, he confirmed his expectation was nursing was to observe all residents taking their medications and medications were not to be left unattended at a resident's bedside.

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 18947 Based on record review, interview, and facility policy review, the facility failed to ensure Code Status was correct throughout the electronic medical record (EMR) for one (Resident (R) R209) out of four residents reviewed for Advance Directives/Code Status. Physician's orders in the EMR indicated the resident's code status as Full Code rather than his preferred Do Not Resuscitate (DNR) in the event the resident was found not breathing and/or without a pulse. This failure created the potential for Cardiopulmonary Resuscitation (CPR) to be performed on the resident when it was not desired. A total of 46 residents were reviewed in the sample. Findings include: Review of the facility's policy titled Code Status Orders Policy dated [DATE] read, in pertinent part, Patient identification mechanisms and information about each patient's code status (Full Code vs. Do Not Resuscitate (DNR) will be easily accessible to the clinical staff for all patients; and Upon admission/re-admission, a code status order is required as soon as possible a part of the patient's admission process; and 2. Staff should verify the patient's wishes with regard to code status (Full Code vs. DNR) upon admission. 2.4 If the patient's wishes are different than the admission orders, immediately document the patient's wishes in the medical record, notify the physician, and obtain the correct order; and Staff should honor the documented verbal wishes of the patient or if applicable, the resident representative regarding CPR while awaiting physician's order. Review of R209's Admission Record, dated [DATE] and found in the EMR under the Profile tab, revealed the resident was admitted to the facility on [DATE]. The record revealed the resident was admitted to hospice services. Review of R209's admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of [DATE] indicated a Brief Interview for Mental Status (BIMS) score of 13 out of 15, which indicated the resident was cognitively intact. Review of two separate New Mexico Orders For Scope of Treatment (MOST) forms, both dated [DATE] were found in R209's EMR. One of the MOST forms was completed with the resident by his hospice team, indicated the resident wished his code status to be DNR. The other form, completed with the resident by the facility team, indicated the resident's designated code status as Full Code. R209 signed both MOST forms. Review of R209's Advance Directive Care Plan dated [DATE], and found in the EMR under the Care Plan tab was reviewed and indicated the resident's designated code status was DNR. Review of R209's Hospice Physician Orders dated [DATE] indicated an order for the resident's code status to be DNR. Review of R209's Initial History and Physical, dated [DATE], and found in the EMR under the Notes tab, indicated the resident's Code Status was DNR. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R209's Physician's Order Report dated [DATE], in the EMR under the Orders tab, indicated orders for the resident's code status to be Full Code. The report indicated the resident's Code Status order was originally DNR upon his admission to the facility on [DATE]. The report revealed the resident's Code Status was incorrectly changed to Full Code on [DATE]. The full code order remained in effect until [DATE]. During an interview with Licensed Practical Nurse (LPN)1 on [DATE] at 8:20 AM, she confirmed she was familiar with R209. She stated the resident's designated code status orders would be found in the EMR. During an interview with the Director of Nursing (DON) on [DATE] at 3:39 PM, she confirmed the resident's code status had been entered as Full Code rather than DNR from [DATE] through [DATE]. She stated her expectation was that each resident's desired code status be reflected correctly in the record. During an interview with the Administrator on [DATE] at 5:49 PM, he stated each resident's code status was expected to be accurately reflected in their record.

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. 18750 Based on record review, interview, and facility policy review, the facility failed to have written documentation of the Skilled Nursing Facility Advanced Beneficiary Notice of Non-Coverage (SNFABN) CMS [Centers for Medicare and Medicaid Services]-10055 and the Notice of Medicare Non-coverage (NOMNC) CMS-10123 for two of three for two of three residents (Resident (R)40 and R86) out of a sample of 46 residents. This had the potential for the residents to be unable to make an informed decision and to be unaware of additional costs and services when skilled services are ending and their right to appeal decisions. Findings include: Review of an undated list of Beneficiary Notice- Residents discharged Within the Last Six Months, document provided by the Administrator, listed residents who were discharged from Medicare covered Part A services with benefit days remaining who either were discharged home or chose to remain in the facility. On the list R40 and R86 were marked as Remaining in the facility. 1. Review of an undated document titled SNF Beneficiary Notification Review for R40, indicated .Medicare Part A Skilled Services Episode State date was: 06/07/24. The last covered day of Part A Services was 07/02/24. The form indicated, The facility-provider initiated the discharge from Medicare Part A Services when benefit days were not exhausted. Further review of the document indicated, Was an SNF/ABN, Form (CMS-10055) provided to the resident? It was marked, No. The explanation given was, facility not doing them. Also, a review of the form revealed the NOMNC was provided and acknowledged by the beneficiary or the representative. A comment was written, but no copy on file. Review of the complete medical record for R40 revealed no documentation that communication took place between R40 and/or the representative to discuss potential additional costs that the resident might have to pay if they chose to continue to receive services. 2. Review of an undated document titled, SNF Beneficiary Notification Review for R86, indicated .Medicare Part A Skilled Services Episode State date was: 03/10/24. The last covered day of Part A Services was 04/20/24. The form indicated, The facility-provider initiated the discharge from Medicare Part A Services when benefit days were not exhausted. Further review of the document indicated, Was an SNF/ABN, Form (CMS-10055) provided to the resident? It was marked, No. The explanation given was, facility not doing them. Also, review of the form revealed the NOMNC was provided and acknowledged by the beneficiary or the representative. A comment was written, But no copy on file. Review of the complete medical record for R86 revealed no documentation that communication took place between R86 and/or the representative to discuss potential additional costs that the resident might have to pay if they chose to continue to receive services. During an interview on 07/18/24 at 8:22 AM, the Social Service Assistant (SSA) was asked about the notices. The SSA stated she did not know anything about the notices. She has been at the facility for three and a half months and had not been trained on how to do them. (continued on next page)

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 07/18/24 at 8:31 AM, the Administrator was asked about the notices and the policy. The Administrator stated, The SNF ABN have not been done, but that will change. The NOMNCs cannot be located, and there are no policies. We follow CMS guidance.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 18947 Based on observation, review of maintenance audits, interviews, and review of facility policy, the facility failed to ensure a comfortable and safe environment throughout the building. Broken/shattered windows and windows without screens were observed in a main hallway and in 18 resident rooms (room [ROOM NUMBER], 111, 115, 117, 118, 119, 120, 121, 122, 123, 126, 128, 130, 132, 139, 143, 153, and 161). This failure created the potential for residents to be injured related to broken glass and created the potential for pests to enter the facility through windows without screens. A total of 46 residents were reviewed in the sample. Findings include: Review of the facility's Preventative Maintenance Policy, most recently revised 01/08/24, read, in pertinent part, Each site will have a program in place that schedules preventative maintenance on equipment and the physical plant. Review of an email exchange between the MD and the facility's corporate office dated 04/02/24 was provided to the survey team and read, in pertinent part, We (the facility) did a resident room by room inspection on all of the windows, we need the following: 28 screens, 18 handles, seven sashes, six crank mechs (mechanisms), two glass is broken (sic), two are falling out of the frame, one broken glass (in the hallway), most are hard to open and close; and response I have a bid to replace the windows at your facility I'm just waiting for the higher-ups to approve it. Observations were conducted of resident rooms on the North wing of the building on 07/18/24 at 12:07 PM. The window by the exit door at the end of the northwest hallway was shattered. The window in room [ROOM NUMBER] was observed to have a diagonal crack measuring approximately 24 inches long on the bottom half of the window. The crack was observed to be secured with tape to prevent the window from breaking completely. The windows in rooms 122, 128, 131, and 132 were observed to have missing window screens. Review of an audit of damaged or missing window screens conducted by the Maintenance Director (MD) on 07/18/24 was provided to the survey team on 07/18/24 and indicated the following resident rooms were without window screens on the windows or had broken window screens on the windows: Rooms 107, 111, 115, 117, 118, 119, 120, 121, 122, 123, 126, 128, 130, 132, 139, 143, 153, and 161. During an interview with the MD on 07/18/24 at 12:07 PM, he confirmed screens were missing from windows and windows throughout the facility were broken. He stated he had received quotes to fix the windows and replace screens for approximately six months, but the quotes had never been approved by individuals in the facility/at the corporate office. He stated, They need to do something about this. The MD stated he thought the facility's recent fly problem (cross reference F925 Pest Control) was, in part, due to windows in residents' rooms being opened with no screens on the windows. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with the Administrator on 07/18/24 at 4:24 PM, he confirmed broken windows and missing screens had been a problem the facility had been aware of since February of 2024. He stated the concerns were on his list of things to deal with. He indicated the issue was something that needed to be addressed.

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 18750 Based on record review, interview and facility policy review, the facility failed to ensure two out of three sampled residents out of a total sample of 46 residents reviewed for hospitalization (Resident (R)19, and R81) and/or their representatives were provided with written transfer notices upon emergent transfer to the hospital. Also, notification was not provided to the ombudsman. This deficient practice could allow a resident to be transferred without knowing their rights. Findings include: Review of the facility policy titled, Discharge and Transfer, revised on 11/14/22 revealed, Policy. For patients transferred to the hospital: 5.1 For unplanned acute transfers for the patient must be permitted to return to the Center. Prior to the transfer, the patent and the patient representative will be notified verbally followed by written notification using the Notice of Hospital or state specific transfer form. 5.2.1 Written notice must also be provided to the Ombudsman. 1. Review of R19's significant change Minimum Data Set (MDS) with an assessment reference date (ARD) of 06/14/24 located in the electronic medical record (EMR) under the MDS tab revealed the facility assessed R19 to have a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated the resident was cognitively intact. Review of R19's Progress Note dated 05/30/24 in the EMR under the Progress Notes tab revealed that the nurse was made aware that R19 was not at baseline vitals. R19 was transported to the hospital via emergency medical services (EMS) due a drop in blood pressure and a low oxygen saturation level of 88% on 4 liters of oxygen. The resident was sent back to the facility on [DATE]. Review of the complete medical record for R19 revealed no evidence that a written transfer was provided to the resident. During an interview on 07/16/24, at 9:30 AM, R19 was asked if he had received written notice of the transfer. R19 stated, No. 2. Review of R81's significant change MDS with an ARD of 06/08/24 in the EMR under the MDS tab revealed the facility assessed R81 to have a BIMS score of three out of 15, indicated the resident had severe cognitive impairment. Review of R81's Progress Note dated 06/30/24 in the EMR under the Progress Notes tab revealed the resident was sent to the hospital after a change in vital signs. The resident was sent back to the facility on [DATE]. Review of the complete medical record for R81 revealed no evidence that a written transfer was provided to the resident and/or representative. During an interview on 07/16/24 at 3:15 PM, Family Member (FM)21 was asked if she had received anything in writing when the resident was sent to the hospital. FM21 stated, No. (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A request was made on 07/17/24 at 1:30 PM for the transfer provided to the resident or representative for R19 and R81. During an interview on 07/18/24 at 2:30 PM, Licensed Practical Nurse (LPN)6 was asked what forms are completed when a resident is sent out to the hospital. LPN6 stated, We fill out a transfer form, gather the face sheet and medication list, call in the report to the hospital, and tell the EMS and we give the EMS the paperwork. I have not given any forms to the resident or representative. During an interview on 07/19/24 at 5:30 PM, the Administrator was asked about the notification of transfer in writing to residents/representatives and notification to the ombudsman. The Administrator stated, We have not been doing that.

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 18750 Based on interview, record review, and review of facility policy, the facility failed to ensure two of two residents (Resident (R) 19 and R81) and/or their representatives out of a sample of 46 residents reviewed for hospitalization were given a written copy of a bed hold notice prior to or within 24-hours of transfer to the hospital. This failure creates the potential for residents and responsible parties not to have the information needed to safeguard their return to the facility. Findings include: Review of the facility policy titled Bed Hold Notice-Deliver Upon Transfer, revised August 2022, revealed, Process. Prior to a resident's transfer out of the center to a hospital for therapeutic leave, the staff member conducting the transfer out will provide both the resident and representative, if applicable, with the Bed Hold Policy Notice & Authorization form. Notice must be given regardless of payer. Resident copy is given directly to the resident prior to transfer and noted in the medical record. Representative copy can be delivered electronically via email/secure fax or hard copy via mail if the representative is not present at the time of transfer. (Must be done within 24 hours. 1. Review of R19's significant change in the Minimum Data Set (MDS) with an assessment reference date (ARD) of 06/14/24 in the electronic medical record (EMR) under the MDS tab revealed the facility assessed R19 to have a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated the resident was cognitively intact. Review of R19's Progress Note dated 05/30/24 in the EMR under the Progress Notes tab revealed R19 was transferred to the hospital due to low blood pressure and oxygen saturation level. The resident was discharged back to the facility on [DATE]. Review of the EMR for R19 revealed no evidence that a copy of the bed hold was provided to the resident and/or representative. During an interview on 07/16/24, R19 was asked if he had received the bed hold policy prior to transfer to the hospital. R19 stated, No. 2. Review of R81's significant change MDSwith an ARD of 06/08/24 in the EMR under the MDS tab revealed the facility assessed R81 to have a BIMS score of three out of 15, indicated the resident had sever cognitive ability. Review of R81's Progress Note dated 06/30/24 in the EMR under the Progress Notes tab revealed R81 was transferred to the hospital due to a significant change in his vital signs. The resident was discharged back to the facility on [DATE]. Review of the EMR for R81 revealed no evidence that a written transfer was provided to the resident and/or representative. (continued on next page)

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	325036	A. Building B. Wing	07/19/2024

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 07/16/24 at 3:15 PM, Family Member (FM)21 was asked if she had received a copy of the bed hold policy when the resident was sent to the hospital. FM21 stated, No. A request was made on 07/17/24 at 1:30 PM, for the bed hold policy provided to the resident or representative for R19 and R81. During an interview on 07/18/24 at 2:30 PM, Licensed Practical Nurse (LPN)6 was asked what forms are completed when a resident is sent out to the hospital. LPN6 stated, We fill out a transfer form, gather the face sheet medication list, call in the report to the hospital, tell the EMS, and we give the EMS the paperwork. I have not given any forms to the resident or representative. During an interview on 07/19/24 at 5:30 PM, the Administrator was asked about the bed hold policy provided to the residents/representatives prior to transfer. The Administrator stated, We have not been doing that.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40902 Based on record review and staff interview, the facility failed to ensure that a Preadmission Screening and Resident Review (PASARR) Level I assessment was completed accurately for two residents (Resident (R)16 and R46) out of two residents reviewed for PASARR screenings out of a total sample of 46 residents. This had the potential for the residents to prevent or delay additional services to the residents that should have had a Level II PASARR completed. Findings include: 1. Review of R16's Admission Record, located in the Profile tab of the electronic medical record (EMR) revealed she was admitted to the facility on [DATE] with diagnoses including depression, obsessive compulsive disorder, schizophrenia, bipolar disorder, post-traumatic stress disorder (PTSD), anxiety disorder, pseudobulbar affect, and psychosis. All of these diagnoses were present upon admission to the facility. Review of R16's quarterly Minimum Data Set (MDS) located under the MDS tab of the EMR, with an Assessment Reference Date (ARD) of 06/08/24, revealed she scored 13 out of 15 on the Brief Interview for Mental Status (BIMS), indicating no cognitive impairment. Further review revealed the resident had active diagnoses of schizophrenia, bipolar disorder, post-traumatic stress disorder (PTSD), anxiety, and psychotic disorder. Review of R16's Level One Nursing Facility Preadmission Screening for Mental Illness, Intellectual Disability, or Related Condition (PASARR) located under the Resident Documents tab in the EMR, dated and submitted on 04/10/23 indicated no mental illness diagnosis, and it was negative for a Level II PASARR to be completed. This was the only Level I PASARR found in the resident's EMR, even though the resident was admitted on [DATE]. 2. Review of R46's Admission Record, located in the Profile tab of the EMR, revealed she was readmitted to the facility on [DATE] with diagnoses including post-traumatic stress disorder (PTSD) as of 01/03/21, anxiety disorder as of 12/04/20, and major depressive disorder as of 12/04/20. Review of R46's quarterly MDS located under the MDS tab of the EMR, with an ARD of 04/24/24, revealed she scored 14 out of 15 on the BIMS, indicating no cognitive impairment. Further review revealed it indicated an active diagnosis of post-traumatic stress disorder (PTSD), anxiety, and major depressive disorder. Review of R46's Level One Nursing Facility Preadmission Screening for Mental Illness, Intellectual Disability, or Related Condition (PASARR), located under the Resident Documents tab in the EMR, dated and submitted on 12/28/21 indicated no mental illness diagnosis, and it was negative for a Level II PASARR to be completed. (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 07/18/24 at 9:40 AM, the Admissions Director (AD) said it was his responsibility to ensure when a new resident was admitted to the facility, there was a PASARR in the system before the resident was admitted to the facility. He said he received some training on ensuring PASARR Level I screenings were completed accurately about four months after his start date. He said prior to that, he only had a vague understanding of PASARR. He said when reviewing them, he looked at the first main section (B & C), which is where he found the most errors. He said he was looking for any contradictions between what was on the PASARR form and what was in the medical record. However, he has not completed a PASARR audit to identify PASARR Level I screenings that were never completed accurately. He said he would expect if a resident had a Mental Illness diagnosis or Intellectual Developmental Disability that, it should be reflected on the PASARR Level I screening, and It should be completed accurately. He said both R46 and R16's PASARR Level I screenings were completed before he started, and he had not identified they were not completed correctly. During an interview on 07/18/24 at 2:48 PM, the Director of Nursing (DON) said she did not have a lot of knowledge related to PASARR screenings; however, she expected them to be done accurately.

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 18947 Based on review of facility policy, record review, and interview, the facility failed to ensure two Residents (R) R18 and R80 of four residents reviewed for activities were provided with an appropriate ongoing program of activities to meet their needs. This failure created the potential for both residents to experience social isolation related to the lack of activity involvement. A total of 46 residents were reviewed in the sample. Findings include: Review of the facility's policy titled Recreation Services Policy and Procedure, dated most recently revised on 08/07/23, read, in pertinent part, Center/Communities must provide, based on the comprehensive assessment and care plan and the preferences of each patient/resident (hereinafter patient), an ongoing program to support residents/patients in their choice of activities, both facility sponsored group and individual activities and independent activities, designed to meet the interests of an support the physical, mental, and psychosocial well being of each patient, encouraging both independence and interaction in the community. Recreation services will be designed to meet the individual's interests, abilities, and preferences through group and individual programs and independent leisure activities. Review of R80's Admission Record dated 07/19/24 and found in the Electronic Medical Record (EMR) under the Admissions Tab, indicated the resident was admitted to the facility on [DATE] with diagnoses including hemiplegia and hemiparesis following a stroke. Review of R80's quarterly Minimum Data Set (MDS) with an Assessment Reference (ARD) date of 04/06/24, found in the EMR under the MDS tab, indicated a Brief Interview for Mental Status (BIMS) score of 13 out of 15, which indicated the resident was cognitively intact. Review of R80's Activities Care Plan dated 06/19/24 and found in the EMR under the Care Plan tab indicated it was important for the resident to have the opportunity to engage in daily routines that were meaningful relative to her preferences. The care plan indicated staff was to plan to visit with R80 a few times during the week to offer items of interest. The care plan indicated it was important to the resident to have access to reading materials such as books and magazines, the resident enjoyed listening to a variety of music, and the resident liked to keep up with the news by discussions with another person, group discussions, listening to the radio, reading magazines, reading the newspaper, using the computer, and watching TV. The care plan indicated R80 liked to use a computer, do crosswords/puzzles/games, listen to music, look out the window, lay down/rest, read, think, and watch TV/movies. Review of R80's Initial Activities Assessment, dated 01/05/24 and found in the EMR under the Assessment tab, indicated magazines, e-books/magazines on computer, music (variety), keeping up with news, spending time by self, watching television, going outside, and voting were all somewhat or very important to the resident. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R80's Quarterly Activities Assessment, dated 07/04/24 and found in the EMR under the Assessment Tab, indicated the resident did not participate in group activities. The assessment indicated R80 participated in daily individual activities, such as TV and chat. The assessment read, in pertinent part, (R80) is a sweet lady who chooses not to get out of bed. She watches TV in her room. We visit a few times during the week to offer items of interest. We delivered some reading to her to thumb through. Review of R80's Activity Participation Logs, dated 05/01/24 through 07/19/24 and provided by the facility, revealed that they were completely blank. There was no documentation of R80's participation in the facility's activities program during that time period. Observation of R80 on 07/15/24 at 11:16 AM and 4:20 PM, on 07/16/24 at 1:32 PM and 4:15 PM, on 07/17/24 at 8:28 AM, 10:34 AM, and on 07/18/24 at 8:56 AM revealed the resident was laying in her bed. The resident's television was on during the observations; however, the resident was not watching the television. No books, magazines, or other activities were observed near the resident or in the resident's room during any of the observations. R80 was not observed to participate in any group activities between 07/15/24 and 07/19/24. During an interview with R80 on 07/16/24 at 10:27 AM, she stated she had not been out of bed. She stated, I want to go to (group) activities. They (staff) don't take me. They don't get me up. During an interview with the Activities Assistant (AA) and the Senior Activity Director (SAD) on 07/17/24 at 12:15 PM, the SAD stated the current AA was new to her job and had not been documenting resident participation in activities correctly. She stated she had been reviewing resident participation records and stated, There is not much in them (the records) at all. During a follow-up interview with the SAD and the AA on 07/17/24 at 12:34 PM, the AA stated she had been employed at the facility as the AA for about three months and had not received facility/job orientation since her date of hire. She stated she had been in R80's room, had met the resident, and stated she tried to get into the resident's room to visit with her once every week or two. The AA stated she was not aware she was supposed to be documenting resident participation in/refusal to participate in activities. When asked if R80 had been provided with a radio or other music source or a computer/tablet to work on per her documented preferences, the AA stated the facility did not have radios or another music source to put in resident rooms and did not have computers to offer. The AA stated, We tried to do karaoke this morning, but we could not find the charger (for the karaoke machine) and could not do it. The AA confirmed group activities were offered in the facility, however, R80 did not attend these activities. 18750 2. Review of R18's Admission Record located in the EMR under the Profile tab revealed the resident was readmitted to the facility on [DATE] with diagnoses of congestive heart failure, cerebral infarction, and cognitive communication deficit. Review of R18's quarterly MDS with an ARD of 07/07/24 located in the EMR under the MDS tab revealed a BIMS score of three out of 15, indicating severe cognitive impairment. The assessment for activities indicated she liked pets, going outside, doing crafts, and socializing. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R18's Care Plan located in the EMR under the Care Plan tab revealed it was important for the resident to have the opportunity to engage in daily routines that were meaningful relative to her preference. Approaches listed included having reading materials at bedside, and the resident liked to listen to music and go outside when the weather was good. Review of the Recreation Participation Record, provided by the facility revealed blanks for July 2024 and no record for June 2024. During observations on 07/15/24 at 11:45 AM, R18 was in a wheelchair at the nurses' station. At 3:00 PM, R18 was observed in her room in the wheelchair. She was not watching TV she was looking at the wall. There were reading materials at the bedside or any music being played. During an observation on 07/16/24 at 10:39 AM, R18 was observed in her room in the wheelchair. She was not watching TV she was looking at the wall. There were reading materials at the bedside or any music being played. During an observation on 07/17/24 at 10:13 AM, R18 was observed in her room in the wheelchair. She was not watching TV; she was looking at the wall. There were reading materials at the bedside or any music being played. During the observations of R18 in her room or at the nurse's station, activities of crafts and games were going on in the activity room. During an interview on 07/17/24 at 12:34 PM, the SAD and AA were asked about the activities, The AA stated R18 will come to activities and color, but it had not been documented.

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F 0680 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure the activities program is directed by a qualified professional. 18750 Based on personnel file review, interview, and facility policy review, the facility failed to ensure the Activities Director (AD) was a qualified professional who was a therapeutic recreation specialist. This failed practice had the potential to affect all the residents of the facility and not meet the interests of the residents. Findings include: Review of the facility's policy titled, Program Design, revised 08/07/23 revealed, Policy: Centers/Communities must provide, based on the comprehensive assessment and care plan and the preferences of each patient/resident (hereinafter patient), an ongoing program to support residents/patients in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each patient, encouraging both independence and interaction in the community. Recreation services will be designed to meet the individual's interests, abilities, and preferences through group and individual programs and independent leisure activities. In skilled nursing facilities, the recreation program must be directed by a qualified professional who is a qualified therapeutic recreation specialist or an activities professional who: Is licensed or registered, if applicable, by the state in which practicing; and is: Eligible for certification as a therapeutic recreation specialist or as an activities professional by a recognized accrediting body on or after October l, 1990; or Has two years of experience in a social or recreational program within the last five years, one of which was full-time in a therapeutic activities program; or Is a qualified occupational therapist or occupational therapy assistant; or Has completed a training course approved by the state. Review of the AD's personnel file revealed she had no specialized training or equivalent for being the AD. During an interview on 07/17/24 at 12:34 PM, the Senior Activity Director (SAD) (who did not work full time at the facility) stated the AD had been signed up to receive the required training, but on the day the training started, she did not go. During an interview on 07/17/24 at 12:45 PM, the Activities Assistant (AA) stated the AD was on vacation and she started three months ago. The AA stated she had received no training. The AA stated she provides the activities but there was no direction from the AD. During an interview on 07/19/24 at 4:47 PM, the Administrator stated, The AD has been here a little over a year, and during that time she has been signed up for the required training twice. It had been scheduled and paid for. The AD came up with reasons not to attend at the last minute. It has been a concern.

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assist a resident in gaining access to vision and hearing services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 18947 Based on record review, and interview, the facility failed to ensure one Resident (R) 80 of one resident reviewed for vision services had glasses available to her per her plan of care. This failure created the potential for the resident to experience negative effects related to not being able to see adequately. A total of 46 residents were reviewed in the sample. Findings include: The facility's policy related to the provision of ancillary services, including vision services, was requested by the survey team on 07/18/24. The policy was not provided to the survey team prior to exit on 07/19/24. Review of R80's Admission Record dated 07/19/24 and found in the Electronic Medical Record (EMR) under the Admissions tab, indicated the resident was admitted to the facility on [DATE] with diagnoses including Hemiplegia and Hemiparesis following a stroke. Review of R80's quarterly Minimum Data Set (MDS) with an Assessment Reference (ARD) date of 04/06/24 and found in the EMR under the MDS tab indicated a Brief Interview for Mental Status (BIMS) score of 13 out of 15, which indicated the resident was cognitively intact. The assessment incorrectly indicated the resident's vision was adequate without glasses. Review of R80's Vision Impairment Care Plan, dated 06/19/24 and found in the EMR under the Care Plan tab, indicated the resident had a vision impairment and required the use of glasses. Review of R80's LTC (Long-Term Care) Evaluation dated 07/06/24 and found in the EMR under the Assessment tab, indicated the resident wore glasses. Review of R80's Physicians Order Report dated 07/19/24 and found in the EMR under the Orders tab, indicated orders for the resident to see the ophthalmologist as needed as needed/indicated for patient health and comfort. Observation of R80 on 07/15/24 at 11:16 AM and 4:20 PM, on 07/16/24 at 10:32 AM and 1:32 PM and 4:15 PM, on 07/17/24 at 8:28 AM, 10:34 AM, and on 07/18/24 at 8:56 AM revealed the resident was not wearing glasses during any of the observations and no glasses were observed in the resident's room. During an interview with R80 on 07/16/24 at 10:32 AM, she stated, I need to see the eye doctor, and (staff) haven't been in to talk to me about that. I wear glasses. I need them to see. The resident stated she did not have her glasses and was not sure the last time she had access to them. During an interview with Certified Nursing Assistant (CNA)12 and CNA16 on 07/18/24 at 10:07 AM, both stated they had never seen the resident wearing glasses. Observation of R80 with CNA 12 on 07/18/24 at 10:09 AM revealed CNA 12 searched the resident's room for her glasses and confirmed she was unable to find them. R80 stated she would wear her glasses if they could be located. (continued on next page)

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with the Director of Nursing (DON) on 07/18/24 at 1:57 PM, she stated staff was expected to follow up if an assessment of a resident indicated the resident wore glasses and no glasses could be found. She stated an appointment would be made for R80 to see an ophthalmologist or optometrist, and glasses would be ordered for the resident if her glasses could not be found.

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 18947 Based on facility policy review, record review, observation, and interview, the facility failed to develop and implement interventions to reduce accident hazards and risk when the facility failed to ensure safety precautions were taken to decrease the risk of burns or injury while smoking for 5 (Residents (R) 78, R36, R10, R31, and R34) of 21 residents reviewed for smoking out of a total sample of 46 residents. Facility policies and procedures related to the storage of smoking material were not enforced, residents were not appropriately assessed for safe smoking, and the facility's smoking area was not adequately supervised. The facility's failure to develop and implement interventions to reduce accident hazards and risks when facility residents were smoking places residents at risk of burns and/or severe injury. The findings are: Review of the facility's Smoking Policy dated most recently revised on 05/01/24 read, Evidence supports the myriad of health risks associated with tobacco and electronic cigarette (e-cigarette) use, both for the smokers and for those exposed to secondhand smoke and aerosol exposure; and For Centers that allow smoking, smoking (including the use of e-cigarettes) will be permitted in designated areas only. Patients/Residents (hereinafter patient) will be assessed on admission, quarterly, and with change in condition for the ability to smoke safely and, if necessary, will be supervised; and 2. For Centers that allow smoking: 2.1 Smoking (including e-cigarettes) will only be allowed in designated areas. 2.1.1 An area designated as a smoking area will be environmentally separate from all patient care areas (e.g., outdoors or a smoking lounge), will be well ventilated, and, if outdoors, will protect patients from weather conditions. 2.1.2 A primary gathering place for patients will not be designated as a smoking area so that non-smokers are not subjected to secondhand smoke. 2.1.3 Oxygen use is prohibited in smoking areas. Precautionary signage will be posted in the designated smoking areas. 2.1.4 Ashtrays made of non-combustible materials and safe design, and metal containers with self-closing covers into which ashtrays can be emptied, shall be provided in al designated smoking areas as well as at all entrances. 2.1.5 Safety equipment such as a fire blanket and portable fire extinguishers will be available within or near the designated smoking area(s). 2.2 The admissions designee will explain the Center's smoking policy to the patients and their families, and inform them that patients will be assessed to determine if supervision is needed. 2.3 The admitting nurse will perform a Smoking Evaluation on each patient who chooses to smoke. 2.3.1 Patients will be re-evaluated with a change in condition. 2.4 The patient will be allowed to smoke only with direct supervision until the interdisciplinary team has evaluated them. 2.5 A care plan for patients who smoke shall include such elements as the need for supervision or physical assistance while smoking and safety devices that are needed, such as a smoking apron to prevent burns. The care plan will be updated, as necessary. 2.6 Smoking supplies (including but not limited to, tobacco, matches, lighters, lighter fluid, batteries, refill cartridges, etc.) will be labeled with the patient's name, room number, and bed number, maintained by staff, and stored in a suitable cabinet kept at the nursing station. 2.7 Center leadership will consider special circumstances on an individual basis (e.g., the need for a smoking apron). 2.8 Patients will be offered education on the risks of smoking. 2.8.1 Education offered/provided will be documented in the medical record. 3. It may be necessary to counsel patients or patient representatives who violate the smoking policy. 4. If there is a willful disregard for safety to others or the Center is jeopardized by a patient's disregard for the smoking policy, termination of smoking privileges and/or initiation of a discharge plan may occur. 4.1 Such action will be documented in the medical record. (continued on next page)

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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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of the facility's Smoking List, provided by the facility, indicated there were 21 smokers in the facility (identified above). 1. Review of R78's Admission Record, found in the Electronic Medical Record (EMR) under the Admissions tab, indicated the resident was admitted to the facility on [DATE] with a diagnosis of Chronic Obstructive Pulmonary Disease (COPD). Review of R78's significant change Minimum Data Set (MDS) assessment, with an Assessment Reference Date (ARD) of 06/11/24 and found in the EMR under the MDS tab, indicated a Brief Interview for Mental Status (BIMS) score of 13 out of 15 which indicated the resident was cognitively intact. Review of R78's Social Services Progress Note, dated 07/20/23 and found in the EMR under the Progress Notes tab, read, in pertinent part, Resident was found smoking in her room. Lighters and cigarettes were confiscated by this worker and given to the nurses station for safe keeping. Resident was educated on the dangers of smoking in her room and was educated on building policy on smoking in the building. Review of R78's Physician Order Report, dated 07/19/24 and found in the EMR under the Orders tab, indicated an order for the resident to receive oxygen continuously via nasal cannula 13 liters per minute (lpm) per oxygen concentrator. Review of R78's Smoking Care Plan, dated 06/17/24 and found in the EMR under the Care Plan tab, indicated the following interventions: Patient will smoke safely x [times] 90 days per smoking assessment. Educate patient/health care decision maker on the facility's smoking policy. Ensure that appropriate cigarette/e-cigarette device(s) disposal receptacles are available in smoking areas. Ensure that there is no oxygen use in smoking areas. Inform and remind patient of location of smoking areas and times. Maintain patients smoking materials at nurse's station. Educate patient/health care decision maker on the facility's smoking policy. Inform family and significant others of the patient's inability to smoke. Review of R78's only Smoking Safety Evaluation dated 03/18/24, and found in the EMR under the Assessment tab, revealed the resident was a smoker. The evaluation indicated the resident had a poor memory and had a history of unsafe smoking practices. The assessment indicated supervised smoking was required for the resident. Review of R78's Physician Encounter Note, dated 10/29/23 and found in the EMR under the Progress Notes tab, read, in pertinent part, (R78) is seen sitting up in her wheelchair looking out the window. She states she is not well but does not know why. She denies pain at this time. Patient became upset and refused to answer any more questions. Returned to patient after staff reports patient lit a cigarette in her room. Patient states she lit it to get someone in her room because she has been waiting for assistance hours. She states she called for water since yesterday and is dehydrated. Unable to complete full interview patient upset. Review of R78's Care Plan Meeting Note, dated 01/04/24 and found in the EMR under the Progress Notes tab, read, in pertinent part, Not aloud (sic) to have cigarettes or lighters. has been found smoking in her room to get Certified Nursing Assistant (CNA) attention last month. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of R78's Care Plan Meeting Note, dated 04/25/24 and found in the EMR under the Progress Notes tab, read, in pertinent part, Discussed residents over all wellbeing, smoking behaviors, weekly activities, and hygiene. Son stated he would talk with his mother about smoking cigarettes in her room is a danger hazard. Review of R78's EMR revealed no evidence that a Behavior Contract had been initiated with R78 related to not following smoking rules. Smoking related incident reports/investigations involving R78 for the previous 12 months were requested of facility Administration on 07/18/24. During an interview with the Director of Nursing (DON) on 07/18/24 at 6:10 PM, she stated she was not aware of any smoking incident occurring in this facility until 07/18/24. Observation of R78 on 07/15/24 at 10:01 AM revealed the resident was in bed sleeping. An unsmoked cigarette was observed in a plastic cup on the resident's overbed table. Smoking related incident reports/investigations involving R78 for the previous 12 months were requested of facility Administration on 07/18/24. During an interview with the Director of Nursing (DON) on 07/18/24 at 6:10 PM, she stated she was not aware of any smoking incident occurring in this facility until 07/18/24. During an interview with R78's family member (FM) 78 on 07/19/24 at 12:55 PM, he stated he had received several calls from the facility related to smoking concerns. He stated staff reported several events, such as when R78 had lit up a cigarette in her room or in her bathroom. He stated the last call he had received related to his mother smoking somewhere other than the designated smoking area had been approximately one month ago (in May or June of 2024). He stated he had been told R78 had been caught smoking in her room, and he was asked to speak to her about it. He stated he told R78 she was going to be in trouble if she continued to smoke in her room. R78's FM stated R78 started a fire at her home prior to being admitted to the facility when she had been smoking with her oxygen on. He stated she had burned the bottom of her foot during the incident and the oxygen tubing had melted during the event. During an interview with CNA 16, Licensed Practical Nurse (LPN)1, and LPN2 on 07/18/24 at 4:34 PM, the staff members were asked if R78 followed the facility's smoking rules, CNA16 stated, I am not going to lie to you. I told them I wouldn't lie. I am not willing to risk my license by not telling the truth. She (R78) gets up at night to smoke and is in bed most of the day. Sometimes, she follows the rules. I have seen cigarettes in her room recently. She usually has them on her person. They are not in the box at the nurse's station. CNA16 removed the metal box used to store resident smoking materials from a drawer at the nurse's station and showed it to the surveyor. The box was empty (no smoking supplies were in the box despite several residents on the unit being active smokers). LPN1 stated all of the residents who smoked on the unit kept their own cigarettes and lighters on their person. LPN2 confirmed R78's oxygen was running in her room continuously all or most of the time due to her order to receive continuous oxygen. LPN2 stated, She has three (oxygen) concentrators there, and she keeps her own lighter and cigarettes in a little black bag in her room. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview with the DON on 07/17/24 at 4:07 PM, she stated she did not know what happened with the smokers in the facility because she did not go out there (to the designated smoking area). She confirmed cigarettes had been found in residents' possession, but staff was not allowed to search a resident's room without permission. She stated if smoking materials were found on a resident or in a resident's room and could be confiscated, they would be. She stated, however, an incident report was not generated for any of those events. The DON stated it was not her expectation that staff would tell her or the Administrator when smoking materials were found on a resident or in a resident's room. She stated her expectation was that the nurses would just take the cigarette away from that person. The DON stated she was aware residents were currently not abiding by the facility's smoking rules and that a lot of residents had been found with random cigarettes. The DON stated facility policy was that all resident smoking material was to be kept at the nurse's station. She stated no residents were allowed to keep their own smoking materials. The DON stated residents could be placed on a Behavior Contract related to smoking if they were not following the smoking rules. However, she was unaware of whether R78 had been placed on a behavior contract related to smoking or not. The DON acknowledged residents not following the facility's smoking rules had the potential to lead to fires and/or serious injury/burns. However, she stated, Between you and I, these residents are going to do what they are going to do. During an interview with the Administrator on 07/18/24 at 5:23 PM, he stated he was not aware of any recent incident reports/investigations related to residents not following smoking rules. He confirmed R78 had not been placed on a Behavior Contract related to smoking previously, but that one had been initiated that day (07/18/24). The Administrator stated he was aware smokers had been keeping their own smoking materials on them. He confirmed his expectation was facility policies and procedures would be followed related to smoking. He stated, What is supposed to be happening is we should be monitoring the cigarettes and lighters more closely. 18750 2. Review of the Admission Record for R36 found in the EMR located under the Profile tab indicated R36 was admitted to the facility on [DATE] with diagnoses of Chronic Obstructive Pulmonary Disease (COPD), Chronic Respiratory Failure with Hypoxia (an absence of oxygen in the tissues to sustain bodily function), and Obstructive Sleep Apnea. Review of the admission MDS admission assessment found in the EMR located under the MDS tab revealed an ARD of 04/22/24. The BIMS score was 15 out of 15, revealing intact cognition. Review of the Care Plan for R36 found in the EMR located under the Care Plan tab revealed a care plan for smoking dated 07/10/24 with an intervention of Monitoring patients' compliance to smoking policy. Review of the Smoking Evaluation for R36 found in the EMR located under the Assessment tab dated 07/10/24 indicated R36 could smoke independently and that R36 was made aware of the smoking policies, time, and location. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on 07/17/24 at 9:56 AM, R36 was up in her motorized wheelchair, returning to her room from outside smoking. R36 wore a lanyard around her neck that held a lighter in it. R36 was asked if she kept her own smoking materials. She stated, Yes, I do. I understand keeping them for residents who are not quite all there, but I am, and I can keep them myself. I know I do not comply with the rules. The resident also stated, Sometimes I go out front and smoke because there are too many that will try and bum a cigarette from me. The resident was asked if she wore oxygen. R36 stated, I do, but not when I'm smoking. During an interview on 07/17/24 at 3:2 PM, Licensed Practical Nurse (LPN)6 revealed R36 could smoke independently, and she would go out and smoke at various times. LPN6 was asked how the resident got her smoking materials to smoke. LPN6 stated, I'm not sure because she does not come to the desk to get them. LPN6 was made aware that R36 kept them with her, and she wears the lighter around her neck. LPN6 stated she was not aware the resident had her own smoking materials. During an interview on 07/17/24 at 3:22 PM, the DON revealed, I am sure that they have their own cigarettes. The staff can do their best to get the materials from the residents, but if we do not have permission to look in their room, then we cannot do anything about it. If the materials are laying out in the open, then we can pick them up. The DON stated, I do not expect an incident report to be done for finding someone with cigarettes. All we can do is talk to the resident, and if it continues, place them on a Behavior Contract. The Administrator makes the decision whether a resident stays or not. I only know of one female resident who has been found with smoking materials, and I cannot remember who it was now. The nurse's station should have everybody's smoking materials. There are blatant people who will not follow the policy. During an interview on 07/18/24 at 7:24 PM, the Administrator said he was not aware of residents keeping smoking materials in their rooms or on their person. 20402 3. Review of R10's quarterly MDS located in the EMR under the MDS tab with an ARD of 04/29/24 indicated R10 scored a 15 out of 15 on the BIMS, indicating no cognitive impairment. Review of Physician Orders, dated 07/17/24 and located in R10's EMR under the Orders tab, indicated, Oxygen at 3 lpm via Nasal Cannula continuously. Review of the Smoking Evaluation, dated 07/18/24 and located in R10's EMR under the Assessments tab, indicated, Independent smoking is allowed. It further indicated, Upon observation, R10 is able to light, smoke, and dispose of smoking materials safely. Review of the Care Plan, initiated on 07/18/24 and located in R10's EMR under the Care Plan tab, indicated, Patient may smoke independently per smoking evaluation. Interventions are: Ensure that there is no oxygen use in smoking area(s), monitor patients' compliance to smoking policy, inform and remind patient of location of smoking areas and times. During an interview on 07/18/24 at 5:40 PM, R10 stated he kept two to three cigarettes in his room in his eye glass case. He further revealed staff did not lock up his cigarettes or lighter. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	4. Review of R31's admission MDS located in the EMR under the MDS with an ARD date of 06/19/24, indicated R31 scored a 12 out of 15 on the BIMS, indicating no cognitive impairment. Review of the Smoking Evaluation, dated 07/03/24 and located in R31's EMR under the Assessments tab, indicated R31 did not wear oxygen, and independent smoking is allowed. Review of the Care Plan, initiated on 07/03/24 and located in R31's EMR under the Care Plan tab, indicated . Patient may smoke independently per smoking evaluation . educate patient on the facility's smoking policy . monitor patients' compliance to smoking policy. During an observation and interview on 07/18/24 at 7:28 PM, R31 stated he was a smoker. R31 revealed he kept his cigarettes and lighters, and they were not locked up by staff. 5. Review of R34's quarterly MDS located in the EMR under the MDS tab with an ARD date of 07/03/24 indicated R34 scored a 15 out of 15 on the BIMS, which indicated no cognitive impairment. Review of the Smoking Evaluation, dated 07/18/24 and located in R34's EMR under the Assessments tab, indicated R34 did not wear oxygen, and Independent smoking is allowed. The smoking evaluation further indicated R34 is able to safely light, smoke and dispose of smoking materials. Review of the Care Plan, revised on 06/20/24 and located in R34's EMR under the Care Plan tab, indicated, R34 may smoke independently per smoking assessment. Interventions are Educate [name of R34] on the facility's smoking policy, inform and remind patient of location of smoking areas and times, ensure there is no oxygen use in smoking area(s). During an interview on 07/18/24 at 6:00 PM, R34 said he kept his cigarettes and lighter on his person and staff allowed him to do so. Staff has never locked up any of my items for me. During an interview on 07/18/24 at 6:45 PM, CNA15 said R10's cigarettes and lighters are locked up and had never seen them in his room. During an interview on 07/18/24 at 6:53 PM, LPN4 said she thought resident cigarettes and lighters were kept at the desk in a small toolbox. The way it was supposed to work is they would come up to the nurse's desk on the approved smoking time, get a cigarette, and go smoke. During an interview on 07/18/24 at 7:31 PM, CNA14 stated, With R31, he has never kept any of his cigarettes and lighters locked up. He keeps them in his fanny pack. We have never kept them locked up. On 07/19/24 at 9:45 AM, the Administrator and Director of Nursing (DON) were notified that Immediate Jeopardy (IJ) existed due to the failure to ensure safety precautions were taken to decrease the risk of burns and/or serious injury when residents were keeping their smoking materials (i.e., cigarettes and lighters) on their person, and smoking in their room with oxygen. This included R78, R36, R10, R31 and R34. The IJ at F689 also constituted Substandard Quality of Care at 42CFR 483,12. The IJ was determined to first exist on 10/29/23 when the Medical Director noted an incident in which staff reported R78 lit a cigarette in her room. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	The facility presented an acceptable plan for removal of the IJ on 07/19/24 at 4:27 PM. The survey team validated that the IJ was removed on 07/19/24 at 6:50 PM following verification conducted onsite that the facility implemented the plan of removal. The deficient practice remained at an E (pattern with potential for minimal harm) scope and severity following the removal of the IJ. The Plan of Removal included: Resident #78's smoking assessment was updated 7 /19/24 at to ensure accuracy and has been identified as a supervised smoker. Her care plan was updated to reflect this. Her room and person were observed for smoking material and none was found, as she was compliant in providing her smoking material to the staff when asked. She was re-educated on the smoking policy and agreed to follow the policy. Family was notified of policy as well (highlighted on the list of emails provided). She does have a history of non-compliance and was given a behavioral contract on 7 /18/24. If she does not adhere to the policy, she will be given a 30-day discharge notice. All residents who smoke were assessed by licensed nursing staff on 7/18/2024 with no injury identified related to smoking. The Administrator/designee began individual meetings with smokers on 7/18/2024 and completed meeting on 7 /19/24 by 3:00pm for the identified residents who smoke at the center to review the smoking policy/process, and/or initiate behavioral contract which includes the following (notes will be in chart that indicate the smoking policy review, and behavior contracts will be uploaded in the chart) The Administrator/designee compiled a list of residents who smoke at the center 7/19/2024 to be placed at the nurses station and will be updated as needed. A whole house sweep of resident smoking materials will be completed on 7 /19/24 by 3:30pm by the Administrator/designee to ensure no items are observed in the resident rooms or observed on the resident and will be obtained if found, or a behavioral contract will be initiated if they do not agree to give up items.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40902 Based on observation, record review, and interview, the facility failed to ensure eight residents (Resident (R)86, R11, R33, R81, R209, R20, R44 and R70) of eight reviewed for oxygen administration out of a total sample of 46 residents received oxygen per nasal cannula according to the physician's order. They failed to ensure there was an order in place for a resident receiving oxygen. This failure had the potential for the resident to receive increased oxygen causing hyperoxia (cells, tissues and organs are exposed to an excess supply of oxygen.) Findings include: 1. Review of R86's Admission Record, located in the Profile tab of the electronic medical record (EMR) revealed admission to the facility on [DATE] with diagnoses of Pulmonary Hypertension, Chronic Obstructive Pulmonary Disease (COPD), Acute Respiratory failure with Hypercapnia. Review of R86's quarterly Minimum Data Set (MDS) under the MDS tab of the EMR, with an Assessment Reference Date (ARD) of 05/07/24, revealed the Brief Interview for Mental Status (BIMS), revealed a score of 15 out of 15 which indicated no cognitive impairment. The resident was coded as receiving oxygen therapy. Review of R86's Care Plan, located under the Care Plan tab of the EMR dated 11/08/23, revealed that the resident is dependent on supplemental oxygen and uses a Continuous Positive Airway Pressure (CPAP) at night. The intervention was to administer oxygen per physician orders. Review of R86 Physician Orders located under the Orders, tab in the EMR, dated 03/10/24, revealed oxygen at two Liters per Minute (lpm) via nasal cannula continuously. Review of July 2024 Treatment Administration Record (TAR) located under the Records tab in the EMR revealed on 07/16/24, Licensed Practical Nurse (LPN)1 documented that R86 was on oxygen at two lpm continuously. During observations on 07/15/24 at 10:56 AM, and on 07/16/24 at 10:40 AM and 3:52 PM, the resident was lying in bed using a nasal cannula, and the oxygen cannister was set at four lpm. 2. Review of R33's Admission Record, located in the Profile tab of the EMR revealed admission to the facility on [DATE] and with diagnosis of acute respiratory failure with hypoxia. Review of R33's significant change MDS under the MDS tab of the EMR, with an ARD of 05/22/24, revealed the BIMS which revealed a score of 13 out of 15, which indicated no cognitive impairment. The resident was coded as receiving oxygen therapy. Review of R33's Care Plan, located under the Care Plan tab of the EMR dated 05/17/24, revealed, Resident is at risk for respiratory complications. The intervention was to administer oxygen per physician orders. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of R33 Physician Orders located under the Orders, tab in the EMR, dated 05/16/24, revealed oxygen at 2 lpm via nasal cannula continuously. Review of July 2024 Medication Administration Record (MAR) located under the Records tab in the EMR revealed on 07/16/24, Licensed Practical Nurse (LPN)1 documented that R33 was on oxygen at two lpm continuously. During observations on 07/15/24 at 10:56 AM, and on 07/16/24 at 10:40 AM and 3:54 PM the resident was lying in bed using a nasal cannula and the oxygen cannister was set at 4.5 lpm. 3. Review of R70's Admission Record, located in the Profile tab of the EMR revealed admission to the facility on [DATE] and with diagnosis of COPD. Review of R70's annual MDS under the MDS tab of the EMR, with an ARD of 05/21/24, revealed the BIMS revealed a score of 14 out of 15 which indicated no cognitive impairment. The resident was coded as receiving oxygen therapy. Review of R70's Care Plan, located under the Care Plan tab of the EMR dated 05/17/24, revealed, Resident is at risk for respiratory complications. The intervention was to administer oxygen per physician orders. Review of R70 Physician Orders located under the Orders, tab in the EMR, dated 05/24/24, revealed oxygen at 5 lpm via nasal cannula continuously. Review of July 2024 TAR located under the Records tab in the EMR revealed on 07/16/24, LPN 1 documented that R70 was on oxygen at 5 lpm continuously. During observations on 07/15/24 at 10:56 AM, and on 07/16/24 at 10:40 AM and 3:55 PM the resident was lying in bed using a nasal cannula and the oxygen cannister was set at 8 lpm. 4. Review of R11's Admission Record, located in the Profile tab of the EMR revealed admission to the facility on [DATE] and with diagnosis of chronic respiratory failure with hypoxia. Review of R11's quarterly MDS under the MDS tab of the EMR, with an ARD of 05/14/24, revealed the BIMS revealed a score of four out of 15 which indicated severe cognitive impairment. The resident was coded as receiving oxygen therapy. Review of R11's Care Plan, located under the Care Plan tab of the EMR dated 05/17/24, revealed, the resident did not have a Care Plan for oxygen use. Review of R11 Physician Orders located under the Orders tab in the EMR, dated 07/15/24, revealed no current order for oxygen. Review of July 2024 TAR located under the Records tab in the EMR revealed there were no orders for oxygen. During observations on 07/15/24 at 10:56 AM, and on 07/16/24 at 10:40 AM and 3:52 PM the resident was lying in bed using a nasal cannula and the oxygen cannister was set at two lpm. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation and interview on 07/16/24 at 3:57 PM Licensed Practical Nurse (LPN) 10 walked into room R86's room and verified the resident's oxygen was set at 4 lpm and admitted she documented on the TAR that it was on 2 lpm per the order. She said she must not have looked at it and that Certified Nursing Assistants (CNAs) were the ones who checked oxygen saturation and wrote down the lpm. However, she agreed she should be verifying a resident was on the correct lpm per the order since she is the one who is documenting it. LPN 10 went into R33's room and verified her oxygen was on 4.5 lpm and that she also documented on the MAR that it was at 2 lpm. We walked into R11's room and verified the resident was receiving oxygen at 2 lpm. She said she was unaware R11 did not have an order for oxygen and that there should be an order. She was unsure how staff were able to know how to monitor the residents' oxygen use without an order. Lastly we looked at the roommate who was R70's who was on oxygen and LPN 10 verified the oxygen setting was set at 8 lpm but the order was for 5 lpm. She said she must not have paid attention when she documented on the TAR that it was on 5 lpm per the order. During an interview on 07/18/24 02:48 PM the Director of Nursing (DON) said it was the responsibility of the nurse to understand the orders for each resident. She expected staff to follow physician orders for oxygen administration. Nurses should be verifying when they were documenting, and if they were unsure they need to go look at the order and make sure. She said they should not be documenting on the MAR or TAR without verifying the orders for themselves. 18947 5. Review of R209's Admission Record, dated 07/19/24 and found in the electronic medical record (EMR) under the Profile tab, revealed the resident was admitted to the facility on [DATE] with diagnoses including Chronic Obstructive Respiratory Disease (COPD) and dependence on supplemental oxygen. Review of R209's admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 07/03/24, indicated a Brief Interview for Mental Status (BIMS) score of 13 out of 15 which indicated the resident was cognitively intact. The assessment indicated the resident was receiving oxygen. Review of R209's Physician's Order Report dated 07/19/24 and found in the EMR under the Orders tab, indicated orders for the resident to receive oxygen 5 to 10 liters/minute (lpm) continuously per nasal cannula. Review of R209's Respiratory Care Plan dated 06/28/24 and found in the EMR under the Care Plan tab indicated the resident had the potential to experience respiratory complications related to COPD. The Care Plan indicated the resident was to receive oxygen as ordered. Observation of R209 on 07/16/24 at 3:45 PM revealed the resident was receiving oxygen via two separate oxygen concentrators. One concentrator was running at eight lpm and was being delivered by mask. The other concentrator was observed to be running at 10 lpm and this oxygen was being delivered to the resident via a nasal cannula, which the resident was observed to be wearing under his oxygen mask. The oxygen R209 was observed to be receiving via the mask was humidified. The oxygen the resident was receiving via nasal cannula was not hooked up to a humidifier. (continued on next page)

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	325036	A. Building B. Wing	07/19/2024

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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation of R209 along with Licensed Practical Nurse (LPN)1) and Certified Nursing Assistant (CNA) 19 on 07/16/24 at 4:42 PM revealed the resident was still receiving oxygen as above. LPN 1 confirmed R80 was receiving 10 liters of oxygen continuously per nasal cannula without humidification and eight liters of oxygen continuously via mask with humidification at the same time. LPN 1 stated R209 should be receiving the oxygen via nasal cannula with humidification and confirmed the nasal cannula was hooked up to the non-humidified concentrator. She stated, We (staff) should not be running oxygen via a nasal cannula at 10 liters at all, and certainly not without humidification. The resident stated his nose was very dry. LPN 1 stated the resident's hospice nurse had been in earlier that day and communicated the resident was receiving 19 liters of oxygen total at the time of her visit. LPN1 stated she though the resident's current oxygen orders indicated he was to receive 10 to 13 liters of oxygen continuously. During a follow-up interview with LPN 1 on 07/17/24 at 8:20 AM, she stated the resident's hospice provider physician had been contacted after the surveyor's observations of the resident on 07/16/24 and the resident's oxygen order had been updated to 10 to 19 liters continuously. 18750 6. Review of the Admission Record for R81 located in the EMR under the Profile tab revealed R81 was readmitted to the facility on [DATE] with diagnoses of Parkinson's disease, anxiety, and dementia. Review of hospital discharge orders dated 07/02/24 for R81 located in the EMR under the Misc tab revealed Oxygen at 1.5 L/min [lpm] via Nasal Canula continuously. every shift. During an observation on 07/15/24 at 11:00 AM, R81 was noted to be on oxygen at 2.5 lpm via nasal canula. During an interview on 07/16/24 at 3:54 PM, Family Member (FM)21 confirmed the oxygen was on 2.5 lpm and should only be 1.5 lpm. During an observation and interview on 07/17/24 at 9:26 AM, Licensed Practical Nurse (LPN)1 confirmed R81's oxygen was set at 2.5 lpm. LPN1 said when the orders were reviewed there was an order dated 07/16/24, Oxygen at 1.5 L/min via Nasal Canula, continuously every day and night. LPN1 stated, The night shift must have put that in last night because that is not what it was. It was at least 2.5 lpm before he went to the hospital. Review of the complete medical chart for R81 revealed an order on 03/06/23 for Oxygen at 2.5 L/min via Nasal Canula. Also, another order dated 03/23/23 to have oxygen discontinued. During an interview on 07/18/24 at 2:29 PM, the DON said she had no explanation for what was happening to R81's oxygen orders. The DON stated, Right now it is 1.5 lpm. 20402 7. Review of R20's Face Sheet located in the EMR under the Med Diag' tab, indicated diagnosis of dependence on supplemental oxygen. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Physician Orders, dated 05/16/20, and located the EMR under the Orders tab, indicated, Oxygen tubing change weekly. Label each component with date and initials every night shift every Sun [Sunday]. Label each component with date and initials. An order was noted to also Clean filter on oxygen concentrator weekly every night shift every Sun [Sunday]. During an observation and interview on 07/15/24 at 1:55 PM, R20 was observed in his room not wearing oxygen. A filter located on the right side of R20's oxygen concentrator was observed to have a thick buildup of white dirt and lint that could be visibly seen from the resident's doorway. R20 stated, I wear oxygen at night when I sleep. He further revealed staff changed out the oxygen tubing usually on Sundays. He was not sure about the care of the filter on the concentrator. During a second observation made on 07/16/24 at 9:43 AM, R20 was not observed in his room at this time. However, R20's oxygen concentrator filter located on the right side of the concentrator was again observed to have the same thick white buildup of lint and dirt on the right side of the concentrator as the day before. During an observation and interview on 07/17/24 at 8:13 AM, the Director of Nursing (DON) stated, The oxygen filters are done by the CNAs (Certified Nursing Assistants). They are changed out by the CNAs on Sundays. No particular shift. The DON further stated, As far as the filters on the oxygen concentrators, there is no log that I know of. The CNAs generally work on the same hall, and everybody assigned would be responsible for their own halls. During an observation with the DON in R20's room, R20's oxygen concentrator filter was again observed to have a thick white buildup of dust and lint. At this time, the DON stated, Yes, it's dirty. I was not aware of this. Nobody told me about that. The CNAs should change those out when they are dirty like this. I can see it was not done. We will have to do some education with our staff. 8. Review of R44's Face Sheet located in the EMR under the Med Diag tab, indicated diagnoses to include obstructive sleep apnea, and chronic respiratory failure with hypoxia. Review of Physician Orders, dated 07/09/23, and located in R44's EMR under the Orders tab indicated, Clean external filter on oxygen concentrator weekly on Sunday nights every night shift every Sunday for Infection control. Review of the Care Plan, revised on 06/03/24 and located in R44's EMR under the Care Plan tab, indicated, Resident is at risk for respiratory complications related to CHF [congestive heart failure]. Interventions on the care plan included, O2 as ordered via nasal cannula. During an observation made on 07/15/24 at 10:31 AM, R44 was not observed in her room. At this time, a black oxygen concentrator was observed at the foot of R44's bed. Further observation of the filter of the oxygen concentrator revealed it to be full of a heavy buildup of white dust and lint buildup in the entire filter and back area. During a second observation made on 07/16/24 at 9:25 AM, R44 was observed to be lying in bed. R44 was not interviewable. Observation of the black oxygen concentrator still located near the foot of R44's bed revealed it to have the same thick heavy buildup of white lint and dirt as the day before. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation and interview with the DON on 07/17/24 at 8:22 AM, R44's black oxygen concentrator was again observed with the same heavy buildup of white lint and dirt was observed with the DON. The DON stated, That is dirty and dusty. I was not aware of this either. It does not look like it has been changed out at all. Surveyor: De Vooght, [NAME] Based on observation, record review, and interview, the facility failed to ensure eight residents (Resident (R)86, R11, R33, R81, R209, R20, R44 and R70) of eight reviewed for oxygen administration out of a total sample of 46 residents received oxygen per nasal cannula according to the physician's order and failed to ensure there was an order in place for a resident receiving oxygen. This failure had the potential for the resident to receive increased oxygen causing hyperoxia (cells, tissues and organs are exposed to an excess supply of oxygen.) Findings include: 1. Review of R86's Admission Record, located in the Profile tab of the electronic medical record (EMR) revealed admission to the facility on [DATE] with diagnoses of pulmonary hypertension, chronic obstructive pulmonary disease (COPD), acute respiratory failure with hypercapnia. Review of R86's quarterly Minimum Data Set (MDS) under the MDS tab of the EMR, with an Assessment Reference Date (ARD) of 05/07/24, revealed the Brief Interview for Mental Status (BIMS), revealed a score of 15 out of 15 which indicated no cognitive impairment. The resident was coded as receiving oxygen therapy. Review of R86's Care Plan, located under the Care Plan tab of the EMR dated 11/08/23, revealed, Resident is dependent on supplemental oxygen as well as using a Continuous Positive Airway Pressure (CPAP) at night. The intervention was to administer oxygen per physician orders. Review of R86 Physician Orders located under the Orders, tab in the EMR, dated 03/10/24, revealed oxygen at 2 Liters per Minute (lpm) via nasal cannula continuously. Review of July 2024 Treatment Administration Record (TAR) located under the Records tab in the EMR revealed on 07/16/24, Licensed Practical Nurse (LPN)1 documented that R86 was on oxygen at two lpm continuously. During observations on 07/15/24 at 10:56 AM, and on 07/16/24 at 10:40 AM and 3:52 PM the resident was lying in bed using a nasal cannula and the oxygen cannister was set at four lpm. 2. Review of R33's Admission Record, located in the Profile tab of the EMR revealed admission to the facility on [DATE] and with diagnosis of acute respiratory failure with hypoxia. Review of R33's significant change MDS under the MDS tab of the EMR, with an ARD of 05/22/24, revealed the BIMS revealed a score of 13 out of 15 which indicated no cognitive impairment. The resident was coded as receiving oxygen therapy. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of R33's Care Plan, located under the Care Plan tab of the EMR dated 05/17/24, revealed, Resident is at risk for respiratory complications. The intervention was to administer oxygen per physician orders. Review of R33 Physician Orders located under the Orders, tab in the EMR, dated 05/16/24, revealed oxygen at 2 lpm via nasal cannula continuously. Review of July 2024 Medication Administration Record (MAR) located under the Records tab in the EMR revealed on 07/16/24, Licensed Practical Nurse (LPN)1 documented that R33 was on oxygen at two lpm continuously. During observations on 07/15/24 at 10:56 AM, and on 07/16/24 at 10:40 AM and 3:54 PM the resident was lying in bed using a nasal cannula and the oxygen cannister was set at 4.5 lpm. 3. Review of R70's Admission Record, located in the Profile tab of the EMR revealed admission to the facility on [DATE] and with diagnosis of COPD. Review of R70's annual MDS under the MDS tab of the EMR, with an ARD of 05/21/24, revealed the BIMS revealed a score of 14 out of 15 which indicated no cognitive impairment. The resident was coded as receiving oxygen therapy. Review of R70's Care Plan, located under the Care Plan tab of the EMR dated 05/17/24, revealed, Resident is at risk for respiratory complications. The intervention was to administer oxygen per physician orders. Review of R70 Physician Orders located under the Orders, tab in the EMR, dated 05/24/24, revealed oxygen at 5 lpm via nasal cannula continuously. Review of July 2024 TAR located under the Records tab in the EMR revealed on 07/16/24, LPN 1 documented that R70 was on oxygen at 5 lpm continuously. During observations on 07/15/24 at 10:56 AM, and on 07/16/24 at 10:40 AM and 3:55 PM the resident was lying in bed using a nasal cannula and the oxygen cannister was set at 8 lpm. 4. Review of R11's Admission Record, located in the Profile tab of the EMR revealed admission to the facility on [DATE] and with diagnosis of chronic respiratory failure with hypoxia. Review of R11's quarterly MDS under the MDS tab of the EMR, with an ARD of 05/14/24, revealed the BIMS revealed a score of four out of 15 which indicated severe cognitive impairment. The resident was coded as receiving oxygen therapy. Review of R11's Care Plan, located under the Care Plan tab of the EMR dated 05/17/24, revealed, the resident did not have a Care Plan for oxygen use. Review of R11 Physician Orders located under the Orders tab in the EMR, dated 07/15/24, revealed no current order for oxygen. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of July 2024 TAR located under the Records tab in the EMR revealed there were no orders for oxygen. During observations on 07/15/24 at 10:56 AM, and on 07/16/24 at 10:40 AM and 3:52 PM the resident was lying in bed using a nasal cannula and the oxygen cannister was set at two lpm. During an observation and interview on 07/16/24 at 3:57 PM Licensed Practical Nurse (LPN) 10 walked into room R86's room and verified the resident's oxygen was set at 4 lpm and admitted she documented on the TAR that it was on 2 lpm per the order. She said she must not have looked at it and that Certified Nursing Assistants (CNAs) were the ones who checked oxygen saturation and wrote down the lpm. However, she agreed she should be verifying a resident was on the correct lpm per the order since she is the one who is documenting it. LPN 10 went into R33's room and verified her oxygen was on 4.5 lpm and that she also documented on the MAR that it was at 2 lpm. We walked into R11's room and verified the resident was receiving oxygen at 2 lpm. She said she was unaware R11 did not have an order for oxygen and that there should be an order. She was unsure how staff were able to know how to monitor the residents' oxygen use without an order. Lastly we looked at the roommate who was R70's who was on oxygen and LPN 10 verified the oxygen setting was set at 8 lpm but the order was for 5 lpm. She said she must not have paid attention when she documented on the TAR that it was on 5 lpm per the order. During an interview on 07/18/24 02:48 PM the Director of Nursing (DON) said it was the responsibility of the nurse to understand the orders for each resident. She expected staff to follow physician orders for oxygen administration. Nurses should be verifying when they were documenting, and if they were unsure they need to go look at the order and make sure. She said they should not be documenting on the MAR or TAR without verifying the orders for themselves. Surveyor: [NAME], [NAME] 5. Review of R209's Admission Record, dated 07/19/24 and found in the electronic medical record (EMR) under the Profile tab, revealed the resident was admitted to the facility on [DATE] with diagnoses including Chronic Obstructive Respiratory Disease (COPD) and dependence on supplemental oxygen. Review of R209's admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 07/03/24, indicated a Brief Interview for Mental Status (BIMS) score of 13 out of 15 which indicated the resident was cognitively intact. The assessment indicated the resident was receiving oxygen. Review of R209's Physician's Order Report dated 07/19/24 and found in the EMR under the Orders tab, indicated orders for the resident to receive oxygen 5 to 10 liters/minute (lpm) continuously per nasal cannula. Review of R209's Respiratory Care Plan dated 06/28/24 and found in the EMR under the Care Plan tab indicated the resident had the potential to experience respiratory complications related to COPD. The Care Plan indicated the resident was to receive oxygen as ordered. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation of R209 on 07/16/24 at 3:45 PM revealed the resident was receiving oxygen via two separate oxygen concentrators. One concentrator was running at eight lpm and was being delivered by mask. The other concentrator was observed to be running at 10 lpm and this oxygen was being delivered to the resident via a nasal cannula, which the resident was observed to be wearing under his oxygen mask. The oxygen R209 was observed to be receiving via the mask was humidified. The oxygen the resident was receiving via nasal cannula was not hooked up to a humidifier. Observation of R209 along with Licensed Practical Nurse (LPN)1) and Certified Nursing Assistant (CNA) 19 on 07/16/24 at 4:42 PM revealed the resident was still receiving oxygen as above. LPN 1 confirmed R80 was receiving 10 liters of oxygen continuously per nasal cannula without humidification and eight liters of oxygen continuously via mask with humidification at the same time. LPN 1 stated R209 should be receiving the oxygen via nasal cannula with humidification and confirmed the nasal cannula was hooked up to the non-humidified concentrator. She stated, We (staff) should not be running oxygen via a nasal cannula at 10 liters at all, and certainly not without humidification. The resident stated his nose was very dry. LPN 1 stated the resident's hospice nurse had been in earlier that day and communicated the resident was receiving 19 liters of oxygen total at the time of her visit. LPN1 stated she though the resident's current oxygen orders indicated he was to receive 10 to 13 liters of oxygen continuously. During a follow-up interview with LPN 1 on 07/17/24 at 8:20 AM, she stated the resident's hospice provider physician had been contacted after the surveyor's observations of the resident on 07/16/24 and the resident's oxygen order had been updated to 10 to 19 liters continuously. Surveyor: [NAME], [NAME] 6. Review of the Admission Record for R81 located in the EMR under the Profile tab revealed R81 was readmitted to the facility on [DATE] with diagnoses of Parkinson's disease, anxiety, and dementia. Review of hospital discharge orders dated 07/02/24 for R81 located in the EMR under the Misc tab revealed Oxygen at 1.5 L/min [lpm] via Nasal Canula continuously. every shift. During an observation on 07/15/24 at 11:00 AM, R81 was noted to be on oxygen at 2.5 lpm via nasal canula. During an interview on 07/16/24 at 3:54 PM, Family Member (FM)21 confirmed the oxygen was on 2.5 lpm and should only be 1.5 lpm. During an observation and interview on 07/17/24 at 9:26 AM, Licensed Practical Nurse (LPN)1 confirmed R81's oxygen was set at 2.5 lpm. LPN1 said when the orders were reviewed there was an order dated 07/16/24, Oxygen at 1.5 L/min via Nasal Canula, continuously every day and night. LPN1 stated, The night shift must have put that in last night because that is not what it was. It was at least 2.5 lpm before he went to the hospital. Review of the complete medical chart for R81 revealed an order on 03/06/23 for Oxygen at 2.5 L/min via Nasal Canula. Also, another order dated 03/23/23 to have oxygen discontinued. During an interview on 07/18/24 at 2:29 PM, the DON said she had no explanation for what was happening to R81's oxygen orders. The DON stated, Right now it is 1.5 lpm. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Surveyor: [NAME], [NAME] 7. Review of R20's Face Sheet located in the EMR under the Med Diag' tab, indicated diagnosis of dependence on supplemental oxygen. Review of Physician Orders, dated 05/16/20, and located the EMR under the Orders tab, indicated, Oxygen tubing change weekly. Label each component with date and initials every night shift every Sun [Sunday]. Label each component with date and initials. An order was noted to also Clean filter on oxygen concentrator weekly every night shift every Sun [Sunday]. During an observation and interview on 07/15/24 at 1:55 PM, R20 was observed in his room not wearing oxygen. A filter located on the right side of R20's oxygen concentrator was observed to have a thick buildup of white dirt and lint that could be visibly seen from the resident's doorway. R20 stated, I wear oxygen at night when I sleep. He further revealed staff changed out the oxygen tubing usually on Sundays. He was not sure about the care of the filter on the concentrator. During a second observation made on 07/16/24 at 9:43 AM, R20 was not observed in his room at this time. However, R20's oxygen concentrator filter located on the right side of the concentrator was again observed to have the same thick white buildup of lint and dirt on the right side of the concentrator as the day before. During an observation and interview on 07/17/24 at 8:13 AM, the Director of Nursing (DON) stated, The oxygen filters are done by the CNAs (Certified Nursing Assistants). They are changed out by the CNAs on Sundays. No particular shift. The DON further stated, As far as the filters on the oxygen concentrators, there is no log that I know of. The CNAs generally work on the same hall, and everybody assigned would be responsible for their own halls. During an observation with the DON in R20's room, R20's oxygen concentrator filter was again observed to have a thick white buildup of dust and lint. At this time, the DON stated, Yes, it's dirty. I was not aware of this. Nobody told me about that. The CNAs should change those out when they are dirty like this. I can see it was not done. We will have to do some education with our staff. 8. Review of R44's Face Sheet located in the EMR under the Med Diag tab, indicated diagnoses to include obstructive sleep apnea, and chronic respiratory failure with hypoxia. Review of Physician Orders, dated 07/09/23, and located in R44's EMR under the Orders tab indicated, Clean external filter on oxygen concentrator weekly on Sunday nights every night shift every Sunday for Infection control. Review of the Care Plan, revised on 06/03/24 and located in R44's EMR under the Care Plan tab, indicated, Resident is at risk for respiratory complications related to CHF [congestive heart failure]. Interventions on the care plan included, O2 as ordered via nasal cannula. During an observation made on 07/15/24 at 10:31 AM, R44 was not observed in her room. At this time, a black oxygen concentrator was observed at the foot of R44's bed. Further observation of the filter of the oxygen concentrator revealed it to be full of a heavy buildup of white dust and lint buildup in the entire filter and back area. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a second observation made on 07/16/24 at 9:25 AM, R44 was observed to be lying in bed. R44 was not interviewable. Observation of the black oxygen concentrator still located near the foot of R44's bed revealed it to have the same thick heavy buildup of white lint and dirt as the day before. During an observation and interview with the DON on 07/17/24 at 8:22 AM, R44's black oxygen concentrator was again observed with the same heavy buildup of white lint and dirt was observed with the DON. The DON stated, That is dirty and dusty. I was not aware of this either. It does not look like it has been changed out at all. Surveyor: De Vooght, [NAME] Based on observation, record review, and interview, the facility failed to ensure eight residents (Resident (R)86, R11, R33, R81, R209, R20, R44 and R70) of eight reviewed for oxygen administration out of a total sample of 46 residents received oxygen per nasal cannula according to the physician's order and failed to ensure there was an order in place for a resident receiving oxygen. This failure had the potential for the resident to receive increased oxygen causing hyperoxia (cells, tissues and organs are exposed to an excess supply of oxygen.) Findings include: 1. Review of R86's Admission Record, located in the Profile tab of the electronic medical record (EMR) revealed admission to the facility on [DATE] with diagnoses of pulmonary hypertension, chronic obstructive pulmonary disease (COPD), acute respiratory failure with hypercapnia. Review of R86's quarterly Minimum Data Set (MDS) under the MDS tab of the EMR, with an Assessment Reference Date (ARD) of 05/07/24, revealed the Brief Interview for Mental Status (BIMS), revealed a score of 15 out of 15 which indicated no cognitive impairment. The resident was coded as receiving oxygen therapy. Review of R86's Care Plan, located under the Care Plan tab of the EMR dat [TRUNCATED]

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 18947 Based on record review, interview, and review of facility policy, the facility failed to ensure one (Resident (R) 80) of one resident reviewed for side rail use had appropriate physicians orders, provided informed consent form, and was appropriately assessed for her use of side rails. This had the potential for possible injury to the resident. A total of 46 residents were reviewed in the sample. Findings include: Review of the facility's policy titled, Bed Rails Policy dated most recently revised on 09/01/22 read, in pertinent part, Centers will only use bed rails as mobility enablers .The Bed Rail Evaluation will be completed upon admission, re-admission, quarterly, change in bed or mattress, and with a significant change in condition. Prior to use/installation of a bed rail, staff will attempt the use of appropriate alternatives. If the alternatives were not adequate to meet the patient's needs, the patient will be evaluated for the use of bed rails; and After appropriate alternatives have been attempted and prior to installation, the Center must obtain informed consent from the patient or patient representative for the use of the bed rails; and If the Bed Rail Evaluation determines that the patient would benefit from bed rails: 2.2 Review the risks and benefits of bed rails with the patient or, if applicable, the patient representative; 2.3 Obtain informed consent from the patient or, if applicable, patient representative, prior to installation using the Consent for Use of Bed Rails form that is part of the Bed Rail Evaluation; 2.3.1 Maintain the consent in the patient's medical record; 2.4 Obtain physician or advance practice provider (APP) order for the use of a bed rail; 2.5 Update care plan and Kardex to reflect use of a bed rail. Review of R80's Admission Record dated 07/19/24 and found in the Electronic Medical Record (EMR) under the Admissions tab, indicated the resident was admitted to the facility on [DATE] with diagnoses including hemiplegia and hemiparesis following a stroke. Review of R80's quarterly Minimum Data Set (MDS) with an Assessment Reference (ARD) Date of 04/06/24 and found in the EMR under the MDS tab, indicated a Brief Interview for Mental Status (BIMS) score of 13 out of 15, which indicated the resident was cognitively intact. The assessment indicated the resident was dependent upon staff to move in her bed and was dependent upon staff for transfers in and out of her bed. The assessment indicated R80 was not using side rails on her bed. Review of R80's Physicians Order Report dated 07/19/24 and found in the EMR under the Orders tab, indicated no orders for the resident's use of side rails on her bed. Review of R80's comprehensive Care Plan dated 06/19/24 and found in the EMR under the Care Plan tab, indicated nothing to reflect the resident's use of side rails Review of R80's most recent Bed Rail Evaluation dated 12/29/23 and found in the EMR under the Assessment tab, indicated bed rails were not recommended for R80. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	There was no evidence in R80's EMR to indicate the resident had been provided with information related to the risk and benefits of using side rails and had given informed consent for the use of side rails on her bed. Observation of R80 revealed the resident's bed had bilateral 1/2 side rails in the raised position at the head of her bed on 07/15/24 at 11:16 AM and 4:20 PM, on 07/16/24 at 1:32 PM and 4:15 PM, on 07/17/24 at 8:28 AM, 10:34 AM, and on 07/18/24 at 8:56 AM. During an interview with the Director of Nursing (DON) on 07/17/24 at 3:30 PM, she confirmed the only side rail assessment in the resident's record (dated 12/29/23) indicated no rails were recommended for R80 on her bed. She confirmed she was unable to locate documentation to indicate a physician's order was in place for the rails, a care plan had been generated for the resident's use of the bed rails, or informed consent for the use of the bed rails had been obtained from the resident. She stated her expectation was a bed rail assessment be conducted for each resident, and if the assessment indicated the resident would benefit from bed rails, informed consent from the resident and a physician's order were to be obtained, and a care plan was to be generated for the use of the rails.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. 18947 Based on record review, observation, interview, and facility policy review, the facility failed to ensure a medication error rate of less than 5%. Two errors were made with a total of 25 opportunities for error, resulting in an 8.0% error rate. The errors involved one (Resident (R) 58) of four residents observed during medication administration. This had the potential for R58 to experience negative effects related to errors with their medication administration. A total of 46 residents were reviewed in the sample. Findings include: Review of the facility policy titled, Medication Errors dated most recently revised on 07/01/24 read, Medication Error means the observed or identified preparation or administration of medication or biologicals which is not in accordance with the prescriber's order; manufacturer's specifications (not recommendations) regarding the preparation and administration of the medication or biological; or accepted professional standards and principles which apply to professional providing services. Types of errors include; medication omission; wrong patient, dose, route, rate, or time; incorrect preparation; and/or incorrect administration technique; and The Center shall ensure medications will be administered as follows; 1.1 According to prescriber's orders; 1.2 Per manufacturer's specifications regarding the preparation and administration of the drug or biological; 1.3 In accordance with accepted standards and principles which apply to professionals providing services. Review of R58's Physicians Order Report, dated 07/19/24 and found in the EMR under the Orders tab, indicated orders for Eye Drops AR Ophthalmic Solution 0.05-0.25% Tetrahydrozoline with Zinc Sulfate) instill one drop in each eye one time daily for dry eyes and Polyethylene Glycol Powder [Miralax] give 17 grams by mouth two times a day for constipation. The manufacturer's directions for use of the Miralax indicated the medication was to be mixed with four to eight ounces of fluid for administration to ensure proper effect. Observation of Licensed Practical Nurse (LPN)3 on 07/17/24 at 8:47 AM revealed LPN3 was not able to administer the resident's Eye Drops AR because the eye drop solution was not available in the facility. R58's Miralax was dissolved in approximately three ounces of water in a four ounce cup and administered to the resident. During an interview with LPN3 on 07/17/24 at 9:17 AM, she confirmed medications were expected to be available in the facility for administration. She stated cups large enough to accommodate Miralax with four to eight ounces of fluid were not available in the facility. After reading the label on the container of Miralax powder she confirmed the medication was expected to be administered with four to eight ounces of water. During an interview with the Director of Nursing (DON) on 07/19/24 at 6:35 PM, she confirmed Miralax was expected to be administered with four to eight ounces of fluid and stated medication was expected to be available in the facility for administration.

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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. 40902 Based on observation, record review, interview, and policy review, the facility failed to ensure staff were taking meal temperatures to ensure they were served at safe temperatures before each meal was served. This had the potential for food borne illnesses and could affect all the residents of the facility who consume food from the kitchen. There were two residents in the sample that were nothing by mouth (NPO). Findings include: Review of the facility's policy titled Food: Preparation, revised 02/2023 revealed, All foods will be held at appropriate temperatures, greater than 135 degrees Fahrenheit (F) (or as state regulation requires) for hot holding, and less than 41 degrees F for cold food holding. Temperature for foods will be recorded at time of service, and monitored periodically during meal service periods. Review of the food temperature logs provided by the Dietary Manager (DM) revealed for the months of April, May, June, and July 2024 revealed April only had documented temperatures from 04/01/24 until 04/14/24. There were no documented meal temperatures for the months of May and June. July only had documented temperatures for one meal on 07/15/24 and for one meal on 07/16/24. There was nothing documented for breakfast or lunch on the 07/17/24. During an interview on 07/18/24 at 12:05 PM Cook1 said she placed all the lunch foods on the steam tray, but she had not temped any of them yet. She was going to temp them, but she got busy and didn't have a chance to do so. She was aware that she should be temping the food when it came off the stove or out of the oven, but she did not. She said she did participate in the in-service on 07/16/24 about staff ensuring temp logs were completed accurately. During an interview on 07/18/24 at 12:10 PM the DM said he was aware that staff were not completing the temp logs at each meal service. He stated he just provided an in-service on 07/16/24 for staff about ensuring temps were taken prior to each meal service. He also stated he was aware that after the in-service staff were still not doing the temp logs. During an interview 07/18/24 at 12:20 PM the District Dietary Manager (DDM) she said she expected staff to complete temp logs. She said no food should be served before the temps have been taken and documented on the logs.

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F 0868 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have the Quality Assessment and Assurance group have the required members and meet at least quarterly 18750 Based on interview and policy review, the facility failed to ensure an effective Quality Assurance and Performance Improvement (QAPI) program by not having the Medical Director attend the meetings. This had the potential for the Medical Directors responsibilities to provide care and direction to the facility and residents to go without direct oversite, and the potential to affect all the residents of the facility. Findings include: Review of the facility policy titled, Center QAPI Process, revised 02/13/16 revealed, Policy: The Center is committed to incorporating the principles of Quality Assurance and Performance Improvement (QAPI) into all aspects of the center work processes, service lines and departments. All staff and stakeholders are involved in QAPI to improve the quality of life and quality of care that our patients and residents experience. 2.2 Is composed of the following individuals: 2.2.7 CED, 2.2.2 Center Nurse Executive, 2.2.3 Medical Director. During an interview on 07/19/24 at 2:30 PM, the Medical Director was asked about an incident in which a progress note from October 2023 noted a resident who had lit a cigarette in her room. She stated that she did not recall the incident. The Medical Director was asked about smoking being an issue that was brought to QAPI. The Medical Director stated it could have been discussed at a QAPI which she did not attend, but she would have talked with the Administrator. The Medical Director was asked if she attended QAPI. She said that if she did not attend, she and the Administrator would meet later and discuss the issues. She was asked if she signs an attendance sheet of some kind to indicate the discussion of the meeting. The Medical Director stated, Yes. During an interview on 07/19/24 at 4:47 PM, the Administrator was asked about the QAPI meetings and who participated. He stated the meetings were broken down into other meetings such as business, clinical, safety, and people. There are several people involved in the meetings, most of them are the directors of the different departments. There is a generalized meeting monthly. The Administrator was asked if he could provide a signature page for all individuals that attended. The Administrator stated he did not have staff sign in. He was asked if the Medical Director would attend. He stated the Medical Director did not attend. The Administrator stated that the Medical Director did come to the facility, and we send her information about the infections, wounds, antibiotics, and antipsychotics. He stated that she gave feedback on those items.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 18947 Based on observation, interview, record review, and review of facility policy, the facility failed to ensure staff were trained in regard to enhanced barrier precautions (EBP) for two of six sampled residents (Resident (R)212 and R208) who had indwelling urinary catheters out of sample of 46 residents. The facility further failed to ensure infection control was maintained related to catheters being observed on the floor for R208 and R212, and lastly the facility failed to properly store respiratory equipment when not in use for R33 and R86. This had the potential for all the residents to acquire infections. Findings include: Review of the facility's policy titled, Procedure: Enhanced Barrier Precautions, revised 05/01/24, revealed, 1. Post the appropriate Enhanced Barrier Precautions (EBP) sign on the patient's room door. 1.1 Enhanced Barrier Precautions (EBP) are to be utilized for the duration of the patient's stay. 1.1.1 Gown and gloves would not be required for patient care activities other than those listed below . The policy further indicated, Follow the CDC guidance per table below. Enhanced Barrier Precautions applies to-All patients with any of the following: Infection of colonization with a targeted MDRO [multidrug-resistant organism] when Contact Precautions do not apply, Chronic Wounds and/or indwelling medical devices (e.g., central line, urinary catheter, enteral feeding tube, tracheostomy, ventilator) regardless of the MDRO colonization status .PPE [personal protective equipment] Used for these situations: During high contact patient care activities: Dressing, bathing/showering, transferring, providing hygiene, changing linens, changing briefs or assisting with toileting, device care of use, central line, urinary catheter, enteral feeding tube, wound care; any skin opening requiring a dressing .Required PPE: Gown, gloves prior to high contact care activity (change PPE before caring for another patient) (Face protection may also be needed if performing activity with risk of splash or spray). 4. Personal protective equipment (PPE) should be accessible and located outside of the patient's room .12. Document: 12.1 Type of precautions in care plan; 12.2 Specific targeted MDRO identification in Special Instructions section of Care Profile in PCC. Review of the facility's policy titled Oxygen Concentrator revised 08/07/23 revealed, it did not indicate how oxygen supplies such as nebulizer masks should be stored when not in use. 1. Review of R208's Admission Record, dated 07/19/24 and found in the EMR under the Profile tab, revealed the resident was admitted to the facility on [DATE] with diagnoses including stage four pressure ulcer to the left buttock and urinary retention. Review of R208's admission MDS with an ARD of 07/03/24, indicated a BIMS score of 13 out of 15 indicating the resident was cognitively intact. The assessment indicated the resident had an indwelling urinary catheter. Observation of R208 07/15/24 at 4:05 PM, on 07/16/24 at 8:53 AM, 9:48 AM, 1:23 PM, 3:55 PM, and 4:48 PM revealed the resident's catheter tubing was observed to be in contact with the floor under her bed and the catheter drainage bag was observed to be laying flat on the floor next to the resident's bed during all of the observations. The drainage bag was not observed to be inside a privacy bag during any of the observations. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation of R208 with Licensed Practical Nurse (LPN) 1 and Certified Nursing Assistant (CNA) 19 on 07/16/24 at 4:48 PM revealed the resident's catheter tubing and drainage bag were on the floor. Both staff members confirmed catheter bags and tubing were not supposed to be in contact with the floor. LPN 1 stated catheter bags and tubing should never be in contact with the floor to prevent potential infection. Additionally, review of R208's comprehensive Care Plan most recently dated 06/28/24 and found in the EMR under the Care Plan tab indicated nothing to indicate the resident had been placed on EBP related to the use of her indwelling catheter. 2. Review of R212's Admission Record, dated 07/19/24 and found in the EMR under the Profile tab, revealed the resident was admitted to the facility on [DATE] with diagnosis of obstructive uropathy. Review of R212's admission MDS with an ARD of 07/12/24, indicated a Brief Interview for Mental Status (BIMS) score of 13 out of 15 (cognitively intact). The assessment indicated the resident had an indwelling urinary catheter in his bladder. Review of R212's comprehensive Care Plan most recently dated 07/16/24 and found in the EMR under the Care Plan Tab indicated nothing to show the resident had been placed on EBP related to his indwelling catheter. During an interview on 07/16/24 at 1:16 PM, with the Senior Infection Control Preventionist (SIP) (who was assisting this facility in the absence of the current IP) revealed when residents came in the facility they do a chart audit, and most of the time, [name of the current IP] will let us know if anyone is on EBP. The SIP further revealed if there were chronic wounds, catheters, PICC lines they would expect the resident to be on EBP. During an interview with Certified Nursing Assistant (CNA) 12 on 07/16/24 at 4:08 PM, she started she was very familiar with the residents in the facility, but had not been educated about EBP or informed of who on the unit was on EBP until that day when administrative staff had conducted education with staff on EBP. During an interview on 07/16/24 at 4:14 PM, the Director of Nursing (DON) stated, We had a misunderstanding of EBP and what that means, and who is supposed to be on EBP. From our part, we identified those people with Foley catheters, IVs, receiving enteral feeding, chronic wounds, suprapubic or indwelling catheters all need to be placed on EBP. We did an audit just today and will be taking care of that right now. The DON revealed she had not been keeping up with the newest guidance from the Centers of Medicare and Medicaid Services (CMS) regarding EBP. During an interview with LPN 3 on 07/16/24 at 4:19 PM, she stated she had been working in the facility for six weeks as a contract nurse. She stated she was aware of what EBP were because she had been trained on it at other facilities, however this facility had not provided any training to her related to EBP or informed her of which residents were on EBP. 40902 (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3. Review of R86's Admission Record, located in the Profile tab of the electronic medical record (EMR) revealed admission to the facility on [DATE] and with diagnosis of pulmonary hypertension, chronic obstructive pulmonary disease (COPD), acute respiratory failure with hypercapnia. Review of R86's quarterly Minimum Data Set (MDS) under the MDS tab of the EMR, with an Assessment Reference Date (ARD) of 05/07/24, revealed the Brief Interview for Mental Status (BIMS), revealed a score of 15 out of 15 which indicated no cognitive impairment. The resident was coded as receiving oxygen therapy. During observations on 07/15/24 at 10:56 AM, on 07/16/24 at 10:40 AM and 3:52 PM the resident's nebulizer machine and mask was lying on top of the dresser at the bedside uncovered. R86 said she did use her nebulizer mask at times. 4. Review of R33's Admission Record, located in the Profile tab of the EMR revealed admission to the facility on [DATE] and with diagnosis of acute respiratory failure with hypoxia. Review of R33's significant change MDS under the MDS tab of the EMR, with an ARD of 05/22/24, revealed the BIMS revealed a score of 13 out of 15 which indicated no cognitive impairment. The resident was coded as receiving oxygen therapy. During observations on 07/15/24 at 10:56 AM, on 07/16/24 at 10:40 AM and 3:54 PM the resident's nebulizer machine and mask placed on bedside dresser uncovered. During an observation and interview on 03/06/24 at 2:37 PM, Licensed Practical Nurse (LPN)5 stated the nebulizer mask went in a plastic bag that was dated and the bag was ziplocked closed to prevent air from getting in which was an infection control issue. LPN5 observed R33's nebulizer mask in an unsealed bag and stated that the tubing was still attached to the mask so there was no way to seal the zip lock bag. During an observation and interview on 07/16/24 at 03:57 PM LPN 10 verified that R86 and R33's nebulizer masks were lying uncovered in the open on their bedside dressers. She stated the masks should be discarded or stored properly in a sealed bag to prevent possible infection and prevent it from coming into contact with stuff on the floor which could spread germs. During an interview on 07/18/24 at 2:48 PM the Director of Nursing (DON) said she expected nebulizer masks and oxygen tubing to be stored in a Ziploc bag when not in use with dent's name and date and changed out weekly.

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. 18947 Based on observation and interview, the facility failed to ensure an effective pest control program within the facility. Flies were observed in multiple areas of the building during the survey. This failure created the potential for cross contamination related to the fly infestation. A total of 46 residents were reviewed in the sample. Findings include: A request for the facility's policy related to pest control was requested by the survey team on 07/18/24, however one was not provided prior to survey exit on 07/19/24. During observations of Resident (R) 80 revealed two flies buzzing around the resident's head and food while she was eating her lunch on 07/15/24 at 1:44 PM, two flies buzzing around the resident's head and landing on her left leg and foot on 07/16/24 at 10:26 AM, one fly buzzing around the resident on 07/16/24 at 1:32 PM, and two flies buzzing around the in the hallway immediately outside of the resident's room on 07/16/24 at 4:15 PM. During an interview with R80 on 07/16/24 at 10:26 AM, the resident swiped at a fly buzzing around her head and stated, They (flies) are always around. A fly swatter was observed on the resident's bed near her feet out of her reach. During observations of R42 revealed two flies buzzing around the resident's head and lunch tray while he was eating his lunch on 07/15/24 at 1:44 PM and one fly buzzing around the resident on 07/16/24 at 1:36 PM. During an interview with R42 on 07/15/24 at 1:36 PM, he stated flies had been a problem recently and they were Driving him crazy. The resident pulled a fly swatter from his bed and swatted at the flies. During observations on 07/18/24 revealed 13 residents were observed sitting in the facility's main dining room and seven flies were observed flying around the dining room, landing on residents, resident food and drink cups, chairs, tables, and silverware. As the residents' lunch was served, residents were observed swatting flies from their food and drink cups. Three of the residents seated in the dining room stated the fly issue had been bad. One resident stated the flies had been worse than usual lately, and they were not sure why. Another resident, who was observed to have a paper napkin covering the top of his juice glass, stated the napkin was in place to keep flies from landing on the rim of his glass. During an interview with Certified Nursing Assistant (CNA)12, Licensed Practical Nurse (LPN) 2, and LPN 6 on 07/18/24 at 11:12 AM, revealed all three staff members stated the flies on the unit had been horrible recently. LPN 6 stated, It's bad. I don't know what the deal is down that hallway (the hallway R42 and R80 lived on). All three staff members stated the flies had also been bad at the nurse's station during the week prior to survey. They stated both R46 and R80 had been complaining to them about the flies. When asked if they had put a work order in to address the flies, all three staff members stated they had not. (continued on next page)

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with the Maintenance Director (MD) on 07/18/24 at 12:07 PM, he stated he was aware flies had been a problem in the facility for the past few days. He stated screens were missing on some of the windows in the facility (cross reference F584 Safe/Clean/Homelike Environment) and he thought the flies were entering the facility through open windows without screens. The MD stated the pest control company was at the facility routinely on a monthly basis, and no concerns were noted regarding flies. However, he had not reached out to them to come to the facility to specifically address the recent fly problem. During an interview with the Administrator on 07/18/24 at 4:24 PM, he stated his expectation was pest control should be effective within the facility.

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F 0943 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give their staff education on dementia care, and what abuse, neglect, and exploitation are; and how to report abuse, neglect, and exploitation. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 18947 Based on review of personnel records, interview, and review of facility policy, the facility failed to ensure three employees (Activities Assistant (AA), Certified Nursing Assistant (CNA) 22 and CNA 23) of 31 staff members reviewed for the completion of required training were trained related to the facility's abuse processes and procedures prior to working in direct contact with residents. This failure created the potential for residents to be abused and/or for facility policies and procedures to not be followed in the event of potential abuse. A total of 46 residents were reviewed in the sample. Findings include: Review of the facility's Abuse Prohibition Policy and Procedures most recently dated revised on 10/24/22 read, in pertinent part, Purpose: To ensure the Center staff are doing all that is within their control to prevent occurrences of abuse, mistreatment, neglect, exploitation, involuntary seclusion, injuries of unknown source, and misappropriation of property for all patients; and Training and reporting obligations will be provided to all employees - through orientation, Code of Conduct training, and a minimum of annually - and will include: 4.1 the abuse prohibition policy; 4.2 appropriate interventions to deal with aggressive and/or catastrophic reactions of patients; 4.3 how staff should report their knowledge related to allegations without fear of reprisal; 4.4 how to recognize signs of burnout, frustration, and stress that may lead to abuse; 4.5 effective communication skills with patients, caregivers and patients' representatives; 4.6 what constitutes abuse, neglect, and misappropriation of patient property; 4.7 prohibition of staff from suing any type of equipment (e. g. cameras, smart phones, and other electronic devices) to take, keep, or distribute photographs and recordings of patients that are demeaning or humiliating; 4.8 dementia management and patient abuse prevention; and 4.9 understanding behavioral symptoms patients that may increase the risk of abuse and neglect and how to respond. 1. Review of AA's personnel record revealed the AA was hired on 04/22/24. The record revealed the AA had been working in direct contact with residents on a full-time basis since her date of hire and there was no evidence of the employee completing any abuse training prior to 07/17/24 when the survey [NAME] requested it. During an interview with the AA and the Corporate Activities Director on 07/17/24 at 12:34 PM, the AA stated she had never received the facility's employee orientation. She confirmed no facility training related to abuse and neglect had ever been conducted with her since her date of hire and confirmed she had been working directly with residents since her date of hire. The Corporate Activities Director stated all employees were expected to receive the facility's abuse training prior to working in direct contact with any resident. During an interview on 07/17/24 at 1:56 PM, the Administrator indicated the AA had been through some of the training required for orientation to the facility and she had 90 days after her date of hire to finish all of the required training. The Administrator was not able to provide any documentation to show any of the completed training included the facility's required abuse training. (continued on next page)

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	07/19/2024

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

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

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F 0943 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Review of CNA22's personnel record revealed the CNA was hired on 11/18/22. The record revealed CNA22 had been working in direct contact with residents on an as needed basis since her date of hire. The CNA's personnel record revealed no evidence the CNA had received the facility's required annual abuse training at any time during the previous 12 months prior to 07/17/24. 3. Review of CNA23's personnel record revealed the CNA was hired on 08/01/17. The record revealed CNA22 had been working in direct contact with residents on an as needed basis since her date of hire. The CNA's personnel record revealed she had not received the facility's required annual abuse training at any time during the previous 12 months prior to 07/17/24. During an interview with the Director of Nursing (DON) and the Facility Nurse Educator (NE) on 07/19/24 at 6:22 PM, both confirmed no documentation could be found to show the AA, CNA 22, and CNA 23 had received their required abuse training upon hire and/or within the last 12 months. The DON confirmed the staff members had been working in the facility in direct contact with residents recently. During a follow-up interview with the DON on 07/19/24 at 6:51 PM, she stated her expectation was all staff members were to complete the facility's required abuse training upon hire prior to working in direct contact with residents and at least annually thereafter to ensure protection of residents from abuse.