STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	325058	A. Building B. Wing	07/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Good Samaritan Society - Grants	840 Lobo Canyon Road Grants, NM 87020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 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. 50752 Based on observation and interview, the facility failed to treat residents with respect and dignity for 2 (R #10 and R # 31) of (R #10 and R # 31) residents randomly identified when the staff failed to knock on the resident's bedroom door before they entered the resident's room. This deficient practice could likely result in residents feeling unimportant and not having privacy. The findings are: A. On 07/09/24 at 12:37 pm, during an observation of staff interaction, Registered Nurse (RN) #1 entered R #10's room, RN did not knock on R #10's door prior to entering the room. R #10 was asleep on his bed. B. On 07/09/24, at 12:38 pm, during an observation of staff interaction, RN #1 entered multiple empty room (residents were in the recreation room socializing), without knocking, . RN #1 found Certified Medical Assistant (CMA) #1 and asked for help. Both staff proceeded back into the R #10 room again without knocking. C. On 07/09/24 at 12:40 pm, during an observation of staff interaction, RN #1 entered R # 31's room without knocking to perform personal care. D. On 07/09/24 at 12:41 pm, during an interview, CMA #1 stated that it is call light policy for staff to knock on the residents' door and announce why staff are entering the room. CMA #1 stated that they were in a hurry looking for wipes for another resident.

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

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Reasonably accommodate the needs and preferences of each resident. 50752 Based on record review, observation, and interview, the facility failed to provide reasonable accommodations of resident needs for 1 (R #10) of 1 (R #10) resident reviewed for care when the facility failed to ensure that the resident call light was within the resident's reach and signs were in the preferred language (Navajo-Dine). This deficient practice could likely result in the residents' needs not being met, leaving them at risk of accidents and falls. The findings are: A. During observations of R #10 the following was revealed: 1. On 07/08/24 at 10:24 am, R #10 laid in bed and the call light was under the bed. 2. On 07/08/24 at 12:15 pm, R #10 laid in bed and the call light was under the bed. 3. On 07/09/24 at 09:13 am, R #10 laid in bed and the call light was under the bed. 4. On 07/09/24 at 12:30 pm, R #10 laid in bed and the call light was under the bed. B. On 07/09/24 at 12:36 pm, during an interview with Certified Medical Assistant (CMA) #1, she confirmed the following: 1. R #10 does need occasional assistance getting out of bed. 2. R #10 does need to have his call light within reach due to having multiple falls in the past. C. Record review of R #10's care plan revised on 11/27/23, revealed that the call bell and personal items are within resident's reach. Encourage resident to use the call bell to request assistance PRN (as needed). Record Review of the care plan for R # 10, revised 11/27/23, revealed place a chair at the nurses' station with signage in English and Navajo with a picture of a person sitting. Add signage to the chair in 400 hall lounges. Upon observation there was no signage anywhere on the 400 hall that was in Navajo/Dine', so the residents that speak or read Navajo/Dine'. D. On 07/12/24 at 11:32 am, during an interview with Social Services, she confirmed that the sign should be on the 400 hall.

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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 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. 50752 Based on observation and interview, the facility failed to provide a comfortable and home-like environment for all 33 residents (residents were identified by the census provided by the Administrator on 07/08/24) when they failed to clean mice dropping on the floor in multiple areas of the facility. This deficient practice could likely cause residents to feel like they are not living in a comfortable, home-like environment and are not valued. The findings are: A. On 07/08/24 at 11:30 am, during an observation of the main conference room, mice dropping were along the walls and behind the trash can. B. On 07/09/24 at 1:22 pm, during an observation of the main dining area, mice droppings were along the walls and behind the door that enters the dining area. C. On 07/09/24 at 1:32 pm, during an observation of the secondary dining area, mice droppings were along the walls and behind the bookshelf. D. On 07/11/24 at 11:30 am, during an observation of multiple rooms in the 400 halls the following were revealed: 1. Room # 410- mice dropping on the north wall floor under the window along the wall. 2. Room # 402- mice dropping on the north wall floor under the window where the fall pad was located. 3. Room # 401- mice dropping on the north wall under the window along the wall. E. On 07/12/24 at 11:30 am, during an interview, Certified Medical Assistant (CMA) #1 stated, staff have seen mice in the dining area and the rooms. She stated that she and other staff, along with housekeeping, had let the management know. F. On 07/15/24 at 12:13 pm, during an interview with the Administrator, he stated that the main conference room was used for the resident council meetings and the Care Plan meeting. He stated that housekeeping cleans the conference room daily Admin confirmed that the mice issue was being addressed with maintenance. G. On 07/15/24 at 12:22 pm, during an interview with the housekeeper, she stated that she sees mice dropping around the building but does her best to sweep and mop daily. She states that the housekeeping does deep cleaning when they have extra time.

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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. 40795 Based on observation and interview, the facility failed to maintain infection control practices for 1 (R #31) of 1 (R #31) residents reviewed for catheter care (the practice of properly utilizing a Foley catheter and catheter bag. The Foley catheter is a tube that is inserted into a patient's bladder to remove urine. The catheter bag is where the urine is drained into). This deficient practice could likely result in the resident being susceptible to infection. A. On 07/08/24 at 10:55 am, during an observation, R #31 was resting in bed, with the bed in the lowest position. R #31's urine catheter bag was attached to the bottom rail of his bed. Due to the position of the bed, the catheter bag was resting on the floor. B. On 07/09/24 at 2:10 pm, during an observation, R #31 was resting in bed, with the bed in the lowest position. R #31's urine catheter bag was attached to the bottom rail of his bed. Due to the position of the bed, the catheter bag was resting on the floor. C. On 07/09/24 at 2:12 pm, during an interview with Registered Nurse (RN) #1, she confirmed the catheter bag was on the floor. She also confirmed that the catheter bag should not be resting on the floor.

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Keep all essential equipment working safely. 40671 Based on observation and interview the facility failed to ensure essential equipment was in safe operating condition by not replacing a broken plastic light covering for a light located directly over the cooking area of the stove. This deficient practice has the potential to affect all 33 residents on the facility census that was provided by the administrator on 07/08/24. The findings are: A. On 07/08/24 at 10:13 am during the initial tour of the kitchen, there was a light in the stove hood that had a broken plastic light cover which had tape holding part of the cover together. Pieces of tape hung off of the cover; and a piece of the plastic cover was completely missing. B. On 07/11/24 at 11:07 an during an interview, the dietary manager stated that the light cover on the oven hood had been broken since he started working at the facility in September of 2023. He also stated that he had not put in a paper work order to repair or replace the light cover but that he has verbally requested this to be fixed. He further stated that he was unsure as to if or when this light cover will be repaired and confirmed that there was loose and old/dirty tape used to hold the light cover together that was hanging loosely off of the light cover.