STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	325060	A. Building B. Wing	05/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Odelia Healthcare	1509 University Boulevard NE Albuquerque, NM 87102

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 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Not transfer or discharge a resident without an adequate reason; and must provide documentation and convey specific information when a resident is transferred or discharged. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48645 Based on record review and interview, the facility failed to readmit 1 (R #1) of 1 (R #1) resident back to the facility after being sent to the hospital for evaluation and treatment. This deficient practice is likely to result in a resident experiencing anxiety, confusion, and despair over not being allowed to return to their residence. The findings are: A. Record review of the facility face sheet, dated 05/02/24, for R #1 revealed she was admitted on [DATE] with an admitting diagnoses of broken left leg, high blood pressure, gastro-esophageal reflux disease (GERD; heart burn), and generalized muscle weakness. B. Record review of the facility census showed R #1 was transported to the hospital on 02/28/24 after a fall in the facility. C. Record review of the hospital discharge paperwork, dated 02/28/2024, for R #1 revealed R #1 did not sustain an injury in her fall at the facility that required her to be admitted to the hospital, and it was recommended she return to the facility. D. Record review of the hospital social worker's discharge notes, dated 02/28/24, showed the hospital social worker called the facility on 02/28/24 at 11:42 pm to arrange R #1's transportation back to the facility, but the facility's social worker told the hospital social worker that R #1 could not return to the facility. The facility's social worker stated the resident could not return, because they believed the resident required a memory care unit or a sitter (one-on-one observation of a resident) due to her dementia. E. Record review of the electronic medical record for R #1 revealed the record contained a bed hold release agreement (written document explaining how long the facility will hold the residents room while they are out of the facility), dated 02/29/24. Further review revealed the document was signed by the Administrator but not by R #1 or their representative. The document contained a handwritten statement, Facility not accepting back. Patient admitted to hospital. Better suited in a memory care facility. (continued on next page)

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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	F. On 05/02/24 at 10:14 am, during an interview with the facility's social services director (SSD), she stated she had no idea why R #1 could not come back to the facility. The SSD stated she did not remember speaking with anyone from the hospital or telling anyone R #1 could not return to the facility. The SSD looked at R #1's electronic medical record and stated she did not see a reason why R #1 could not be readmitted to the facility. G. On 05/02/24 at 11:19 am, during an interview with the Assistant Director of Nursing (ADON), she stated R #1 had a Brief Interview for Mental Status (BIMS; a screening for cognitive impairment) score of 6 out of 15 (severe impairment) and did not have any safety awareness. The ADON stated she thought R #1 would be better cared for in a memory care facility. The ADON stated staff placed a wander guard (wearable devise that sounds an alarm and locks doors if near an exit) on R #1 on 02/23/24, because staff saw the resident go towards the front door while stating she did not want to be at the facility anymore. The ADON stated this was the only time R #1 mentioned that she wanted to leave the facility. The ADON stated the staff did not contact R #1 or her Power of Attorney (POA; legal authorization for a designated person to make decisions about another person's property, finances, or medical care) while the resident was at the hospital. H. On 05/02/24 at 11:25 am, during an interview with the facility Administrator, she stated staff did not talk to R #1 or the resident's POA about the resident not returning to the facility. The Administrator stated she thought R #1 would be better cared for in a memory care facility. The Administrator reviewed the bed hold release agreement from R #1's medical record and stated she wrote the note on the document. The Administrator stated her expectation for a facility initiated discharge would be for the staff to communicate with the resident or the resident's POA during the process. I. On 05/03/24 at 12:00 pm, during an interview with the hospital social worker, she stated she called the facility to arrange for transportation for R #1 back to the facility, and she was told by someone in social services that the facility would not accept R #1 back into the facility. J. On 05/03/24 at 12:15 pm, during an interview with R #1's POA, he stated he never spoke with anyone at the facility. The POA stated he was told by the hospital staff on 02/28/24 that they contacted the facility, and the facility refused to let R #1 return. The POA stated R #1 really liked the facility, and he would have preferred for R #1 to be readmitted there.

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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. 48645 Based on record review and interview, the facility failed to ensure residents, resident representatives, and Ombudsman received a written notice of transfer as soon as practicable for 1 (R #1) of 1 (R #1) residents sampled for being discharged . This deficient practice could likely result in the resident representatives not knowing the reason for discharge, location of the resident, and when the resident can return to the facility. The findings are: A. Record review of R #1's administration progress note, dated 02/28/24, revealed R #1 was admitted to a hospital on 02/28/24. B. Record review of R #1's discharge Minimum Data Set (MDS; a federally mandated assessment instrument completed by the facility staff), dated 02/28/24, revealed the resident had an unplanned discharge to a short-term general hospital. C. Record review of R #1's hospital discharge notes written by the hospital social worker, dated 02/28/24, showed the hospital social worker called the facility on 02/28/24 at 11:42 pm to arrange R #1's transportation back to the facility, but the facility's social worker told the hospital social worker that R #1 could not return to the facility. D. On 05/02/24 at 11:19 am, during an interview with the Assistant Director of Nursing (ADON), she stated she thought R #1 would be better cared for in a memory care facility. The ADON stated the staff did not contact R #1 or the resident's Power of Attorney (POA; legal authorization for a designated person to make decisions about another person's property, finances, or medical care) while the resident was at the hospital. E. On 05/02/24 at 11:25 am, during an interview with the facility Administrator, she stated staff did not talk to R #1 or the resident's POA about the resident not returning to the facility. The Administrator stated she thought R #1 would be better cared for in a memory care facility. The Administrator stated her expectation for a facility initiated discharge would be for the staff to communicate with the resident and or the POA during the process. F. On 05/03/24 at 12:00 pm, during an interview with the hospital social worker, she stated she called the facility to arrange for transportation for R #1 back to the facility, and she was told by someone in social services that the facility would not accept R #1 back into the facility. G. On 05/03/24 at 12:15 pm, during an interview with R #1's POA, he stated he never spoke with anyone at the facility. The POA stated that on 02/28/24 the hospital staff told him they contacted the facility, and the facility refused to let R #1 return. The POA stated he was never contacted by the facility about R #1's discharge, never given written notice, and was not aware he could have appealed the facility initiated discharge. (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	H. On 05/14/23 at 09:39 am, during an interview with the Ombudsman (provides advocacy and assistance by offering residents a means to voice their concerns and have their complaints addressed) for the facility, he stated the facility did not notify him in writing when they discharged R #1, but they should have.