

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  325068	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  03/14/2024
NAME OF PROVIDER OR SUPPLIER  Belen Meadows Healthcare and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE  1831 Camino Del Llano Belen, NM 87002	

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)
<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure services provided by the nursing facility meet professional standards of quality.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 35632</p> <p>Based on record review and interview, the facility failed to meet professional standards of quality by failing to obtain wound care orders for 1 (R #12) of 3 (R #12, 15, and 16) residents reviewed for pressure sores. If the facility does not get wound care orders, it could create confusion on what wound care should be provided, or the residents may not get wound care. The findings are:</p> <p>A. Record review of the admission history and physical (H and P) for R #12, completed on 12/14/23 indicated the following under skin:</p> <p>-Wound on L (left) heel and big toe of R (right) foot;</p> <p>-Stage 2 pressure wound (sore has broken through the top layer of the skin and part of the layer below wound is open and shallow and could have clear or yellow fluid) on sacrococcygeal (sacrum or tail bone).</p> <p>B. Record review of the face sheet for R #12 revealed the resident was admitted to the facility on [DATE] with a left heel wound and a wound on his right big toe. No documentation of a wound on his tail bone.</p> <p>C. Record review of the physician orders revealed wound care orders starting on 12/13/23 for the left heel and right big toe.</p> <p>D. Record review of the change in condition note for R #12 indicated the following: On 12/16/23 at 3:26 pm, Certified Nurse Assistants (CNA) reported redness and skin break down to the tail bone area, after resident had a shower, this nurse was able to take a swift (picture) on call provider notified, ordered facility skin breakdown protocol (standard orders that the facility would put into place) and for wound care nurse to evaluate on Monday.</p> <p>E. Record review of the wound assessment for R #12 dated 12/16/23 indicated the following for tail bone: Length was 4.25 centimeters (cm), and the width was 3.11 cm, and it was documented as a stage II.</p> <p>F. Record review of a wound care order dated 12/16/23 indicated the following: Wound care for pressure ulcer and facility protocol for skin care. Notify primary team on Monday please.</p> <p>(continued on next page)</p>

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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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>G. Record review of the treatment administration record (TAR) for R #12 revealed the record did not contain any order and any treatment were on the TAR starting on 12/16/23 for the sacrum wound.</p> <p>H. Record review of a nursing progress note dated 12/17/23 indicated the following: wound care for skin breakdown. Resident (R #12) was found to have skin breakdown to bilateral buttocks . Cleaned and optifoam (a type of dressing) placed.</p> <p>I. Record review of the nursing progress notes dated 12/19/23 indicated the following: nurse went in to flush the Foley catheter (removes urine from the body), and the resident needed changing; the nurse helped and assisted CNA and the resident had a dressing on, and this nurse removed and noticed a few wounds to the sacrum. Resident appeared to be scratching at the area and noticed bowel movement (BM) was making resident's tail bone red and inflamed. This nurse cleaned the site and followed up with w/c (wound care).</p> <p>J. On 03/14/24 at 11:49 am, during an interview with wound care nurse, she stated that the first time she was involved with wound care for R #12 was likely on 12/16/23 when she saw the sacral (tail bone) wound and documented it. She stated that she was not clear on why there was no order for wound care on the TAR starting 12/16/23.</p> <p>K. On 03/14/24 at 12:47 pm, during an interview with the Director of Nursing (DON), stated that the wound nurse took a picture, measured and staged the sacrum wound (the use of a staging system to determine the severity of a pressure ulcer; and measuring the size of the wound assist in wound management) on 12/16/23. She stated that it was a stage II. An order was put it on 12/16/23 for wound care. She stated that she is not clear on why this order (noted in finding ) is not showing up on the treatment administration record (TAR). She said that it might have something to do with there not being a schedule for the wound care. She stated that she knew the wound care was being completed because she had conversations about it with the nursing staff. She said that the order was changed and on 12/22/23. She does see that one on the TAR with wound care being completed.</p> <p>L. On 03/14/24 at 2:29 pm, during an interview with the Unit Manager #1, she stated that orders need to be in place for treatment to occur. She stated that if a nurse sees a new dressing on a resident but does not see orders for that dressing or for wound care, the nurse needs to call and get an order for treatment.</p> <p>M. On 03/14/24 at 2:35 pm, during an interview with CNA #1, she stated that she remembers R #12 very well. She has worked with him since he was admitted . She remembers giving him a shower and changing him after he had a bowel movement (BM). She stated that he always had a dressing on sacrum and it appeared clean.</p>		