

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 325070	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/25/2024
NAME OF PROVIDER OR SUPPLIER Red Rocks Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 3720 Church Rock Road Gallup, NM 87301	

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 0552</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure that residents are fully informed and understand their health status, care and treatments.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48645</p> <p>Based on record review and interview, the facility failed to ensure residents or the guardians were aware of and understood the reason they took a medication, the risks, and the benefits of the medication for 2 (R #19 and R #66) of 2 (R #19, R #66) residents reviewed for unnecessary medications. If the residents or their guardians are not informed of the risks of benefits of the medication, they are not able to make informed decisions. The findings are:</p> <p>R #19</p> <p>A. Record review of R #19's physician's orders revealed an order for quetiapine fumarate oral tablet (used to treat certain mental/mood disorders), 50 mg (milligrams). Give one tablet orally at bedtime for agitation. Start date: 05/09/24.</p> <p>B. Record review of R #19's medical record revealed the record did not contain a consent form for quetiapine fumarate oral tablet, 50 mg.</p> <p>C. On 08/29/23 at 2:30 pm, during an interview, the Director of Nursing (DON) stated R #19's medical record did not contain consent forms for quetiapine fumarate oral tablet, 50 mg, and staff did not monitor R #19's behaviors while taking the quetiapine from 05/09/24 thru 07/02/24.</p> <p>40671</p> <p>R #66</p> <p>D. Record review of face sheet for R #66 revealed an admitted [DATE] and included the following diagnoses: Dementia (decline in cognitive abilities that affect memory, thinking, language, and behavior) and drug induced subacute dyskinesia (movement disorder that causes involuntary, repetitive body movements caused by long term use of certain medications).</p> <p>E. Record review of Physicians Orders for R #66 revealed the following:- Buspirone HCl oral tablet (medication used to treat anxiety), 5 mg. Give one tablet by mouth two times a day for anxiety. Start date: 03/25/24.</p> <p>- Risperdal (medication used to treat certain mental/mood disorders) Oral Tablet 1 mg. Give one tablet by mouth two times a day for dementia/behaviors. Start date: 06/24/24.</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 0552</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>F. Record review of medication administration records for R #66, dated 03/25/24 through 07/21/24, revealed staff administered buspirone and risperdal to R #66 daily.</p> <p>G. Record review of electronic medical record for R #66 revealed the record did not contain a signed consent by R #66 or R #66's Power of Attorney (POA) to receive psychotropic medications.</p> <p>H. On 07/24/24 at 10:15 am during an interview with the Director of Nursing, she stated R #66 or the resident's POA should have signed a consent for psychotropic medications on 03/25/24 or within a couple of days of his admitted , if the resident was admitted to the facility with orders for psychotropic medications. She verified a consent form was not completed until 07/22/24, when facility staff did a full sweep of residents who took psychotropic medications.</p>

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>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.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35632</p> <p>Based on observation, interview, and record review, the facility failed to provide a homelike environment for 4 (R # 21, 63, 67 and 201) out of 4 (R # 21, 63, 67 and 201) residents reviewed when staff failed to replace the shower bed mattress that had a large hole all the way through the mattress which exposed the white pipe frame; to replace the curtain rods for multiple rooms; and to fix a broken door into the shower room. If residents do not have a homelike environment, they may become depressed and anxious about things in disrepair. The findings are:</p> <p>Shower bed mattress findings:</p> <p>A. On 07/22/24 at 2:02 pm, during an interview with R #67, she stated the shower bed she used for showers had a large hole in it. She stated the bed hurt her back when she lay on it, and the hole kept getting bigger. She stated it has been like that for months.</p> <p>B. On 07/24/24 10:41 am, during an interview with Certified Nursing Assistant (CNA) #5, she stated the shower bed has been like this for probably a couple of months. She stated R #67 complained about the hole in the mattress. She stated that everyone (nurses and management) were aware of the condition of the shower bed mattress.</p> <p>C. On 07/24/24 at 10:55 am, during an observation of the shower room, the shower bed had multiple cracks on the shower bed mattress. The shower bed also had a large hole that went all the way through the mattress and exposed the pipe frame.</p> <p>D. On 07/24/24 at 11:10 am, during an interview with Administrator, he stated he was not aware the shower bed had a large hole in the mattress. He stated that it was not acceptable for residents to use the shower bed as it was. The Administrator stated the bed should not be used.</p> <p>40671</p> <p>Curtains</p> <p>E. On 07/22/24 at 9:50 am, a random observation of resident rooms revealed the following:</p> <ul style="list-style-type: none"> - room [ROOM NUMBER] - curtains were inappropriately hanging and were falling off the curtain rods. - room [ROOM NUMBER] - curtain were inappropriately hanging and were falling off the curtain rods. <p>F. On 07/22/24 at 9:54 am during an interview, the Housekeeper stated that housekeeping staff reported the broken curtain rods several times and requested the rods be fixed, but it never gets done.</p> <p>G. On 07/24/24 at 10:02 am, random observations of resident rooms revealed the window curtains in resident rooms 43, 46, 47, 51, 64, 66 and 70 were falling off the rods and were missing clips that held the curtains in place. Further observation revealed curtains could not be closed.</p> <p>(continued on next page)</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>H. On 07/24/24 at 12:08 pm during an interview and record review with the Administrator, he stated he was aware of the issue with the curtains, and they purchased extra clips to replace as needed. He stated he was not aware whether or not there were any maintenance requests for the curtain issues. He stated he expected all staff who were aware of any issues to put in maintenance requests. He stated he was not sure why the curtains in the resident rooms were not addressed. The Administrator provided one maintenance request for room [ROOM NUMBER] curtain issues.</p> <p>I. Record review of facility maintenance requests for repairs to curtains in resident rooms revealed one work order, dated 07/22/24, for resident room [ROOM NUMBER] - window curtain rail was bent.</p> <p>Shower room door findings:</p> <p>J. On 07/24/24 at 10:55 am, during an observation of the shower room, the shower room door was broken. A large chunk of the door, which measured approximately 12 inches () by 3 at the widest part, was missing around the handle area, the door did not lock, and the keypad on the door did not work. Further observation revealed a handle on the inside of the door so staff and residents could get out of the shower room.</p> <p>K. On 07/24/24 at 12:07 pm, during an interview with Administrator, he stated initially the door had an issue with latching, and then there was another issue with the door which he could not recall what it was. He stated measurements were taken for a new door, and a new door was ordered. The Administrator stated the issue with the shower room door had been like that for many months. He said it was a long process to get it replaced. He said they relied on outside companies, and it took a long time to get things done.</p> <p>L. On 07/25/24 at 12:30 pm, during an interview with the Maintenance Director, he stated the door sagged, and he put a piano hinge on it to help with the sagging. He stated he was not sure how the door became so damaged, but he was aware the door had been sticking. The Maintenance Director stated it took a little bit of force to open the door. He stated he started to work on the door issue in May 2024. He said the facility tried to get someone local to replace the door, but it took too long for the vendor to get paid. He stated they now have to go through an outside company to get the door replaced.</p>

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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure each resident receives an accurate assessment.</p> <p>50752</p> <p>Based on record review and interview, the facility failed to ensure comprehensive Minimum Data Set (MDS; a federally mandated assessment instrument completed by facility staff) assessments were accurate for 2 (R #70 and #84) of 2 (R #70 and #84) residents reviewed for accurate MDS Assessments. If resident assessments are not complete and accurate, the facility could misidentify clinical complications and fail to provide adequate care to treat the resident's medical condition. The findings are:</p> <p>A. Record review of R #70's admission MDS Assessment, dated 05/21/24, indicated the resident was not on dialysis.</p> <p>B. Record review of R #84's admission MDS Assessment, dated 07/16/24, indicated the resident was not on dialysis.</p> <p>C. On 07/22/24 at 12:11 pm, during an interview with the MDS Coordinator, she verified R #70 was on dialysis at admission, and staff coded his MDS Assessment inaccurately. She also verified R #84 was on dialysis at admission, and staff coded her MDS Assessment inaccurately.</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>48645</p> <p>Based on interview and record review, the facility failed to ensure two (R #11 and R #66) of two (R #11 and R #66) residents had complete comprehensive care plans for their care, when staff failed to:</p> <ol style="list-style-type: none"> 1. Include hospice on R #11's care plan. 2. Ensure R #66's care plans for delirium (a serious change in mental abilities that causes confused thinking and lack of awareness of surroundings), oral health, and use of psychotropic drugs (drugs that affect a person's mental state) were complete and included time frames. <p>This failure had the potential to adversely affect staff's ability to implement preventative measures for the residents' health and well-being.</p> <p>Findings include:</p> <p>Resident #11</p> <p>A. Record review of R #11's comprehensive Minimum Data Set (MDS; a federally mandated assessment instrument completed by facility staff), dated 04/22/24, revealed the resident was on hospice.</p> <p>B. Record review of R #11's comprehensive care plan, dated 05/30/24, did not include R #11 was on hospice.</p> <p>C. Record review of R #11's physician orders showed R #11 started hospice on 04/12/24.</p> <p>D. During an interview on 7/23/24 at 1:57 PM, the Director of Nursing (DON) stated staff did not care plan R #11's hospice until 07/22/24, and the DON did not know why it was not on 04/12/24. The DON expected hospice to be care planned the day it was ordered.</p> <p>40671</p> <p>Resident #66</p> <p>E. Record review of the care plans for R #66 revealed the following:</p> <p>- Dated 03/25/24 - Focus: Resident/Patient was at risk for or exhibited symptoms of delirium related to: [this space left blank]. Goal: Resident/Patient will remain free of signs/symptoms of delirium with no unexplained or rapid changes for [blank] days. Further review revealed the care plan was revised on 07/05/24, but staff did not include time frames for goals to be achieved by.</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>- Dated 03/25/24 - Focus: Resident exhibited or was at risk for oral health or dental care problems as evidenced by [blank]. Goal: 1) The resident will maintain intact oral mucous membranes for [blank] days. 2) The resident will not have any discomfort or chewing problems in the next [blank] days. Further review revealed the care plan was revised on 07/05/24, but staff did not include time frames for goals to be achieved by.</p> <p>- Dated 03/25/24 - Focus: Resident was at risk for complications related to the use of psychotropic drugs. Goal: Resident will have the smallest, most effective dose without side effects for [blank] days. Further review revealed the care plan was revised on 07/05/24, but staff did not include a reason/cause for R #66's delirium or time frames for goals to be achieved by.</p> <p>F. On 07/24/24 at 10:15 am during an interview, the DON verified R #66's care plans were incomplete. She stated she was not sure why the care plans were incomplete, but it is her expectation staff completed the care plans to include a measurable time frame for goals.</p>

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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>Ensure services provided by the nursing facility meet professional standards of quality.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48645</p> <p>Based on record review, and interview, the facility failed to provide pressure ulcer interventions as ordered for R #10. This deficient practice could likely result in the resident not receiving appropriate and timely pressure ulcer relieving interventions, which could result in wounds becoming worse. The findings are:</p> <p>Findings for R #10</p> <p>A. Record review of R #10's electronic medical record showed the resident was admitted on [DATE] with a diagnosis of pressure ulcer of sacral region, Stage 4 (pressure injuries that extend to muscle, tendon, or bone). This is not an all inclusive list.</p> <p>B. Record review of R #10's physician orders, dated 05/19/24, showed an order for a pressure-redistribution cushion to chair and a pressure-redistribution mattress to bed.</p> <p>C. Record review of R #10's physician orders from the wound clinic, dated 07/16/24, showed orders to offload (reduction or redistribution of pressure on a specific area to promote healing and prevent complications) patient every two hours, order a pressure relieving wheel chair cushion, and order a pressure relieving mattress.</p> <p>D. Record review of R #10's physician orders, dated 07/24/24, showed the record did not include an order to turn every two hours.</p> <p>E. Record review of R #10's tasks for the Certified Nursing Aides (CNA) did not include a task to turn the resident every two hours.</p> <p>F. On 07/23/24 at 8:25 am, during observation of R #10's room, a pressure relieving mattress was not on the resident's bed.</p> <p>G. On 07/24/24 at 2:42 PM during an interview of the Director of Nursing (DON), she stated staff did not order the pressure relieving mattress, and she did not know why. She stated the resident did get his wheelchair cushion. The DON stated staff did not enter the order to turn the resident every two hours.</p>		

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<p>F 0687</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate foot care.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35632</p> <p>Based on observation, interview, and record review, the facility failed to provide podiatry (the medical care and treatment of the human foot) services for 1 (R #65) of 1 (R #65) resident reviewed for toenail care. This deficient practice could likely result in functional decline, pain, and infections. The findings are:</p> <p>A. Record review of R #65's face sheet indicated she was admitted on [DATE]. She had a diagnosis of type 2 diabetes (when the body does not use insulin properly), morbid obesity (overweight), Guillan-Barre syndrome (a condition in which the body's immune system attacks the nerves. It can cause weakness, numbness or paralysis) and dementia (symptoms affecting memory, thinking and social abilities severely enough to interfere with daily life). This is not an all inclusive list.</p> <p>B. On 07/21/24 at 6:45 pm, during an interview with R #65, she stated she needed her toenails cut and to see podiatry. She stated she requested this from the nursing staff for awhile now.</p> <p>C. On 07/21/24 at 6:45 pm, an observation revealed bandages around R #65's feet and legs. She had a brace on one of her feet. Her toenails could not be observed.</p> <p>D. Record review of the physician orders for R #65 indicated the following:</p> <ul style="list-style-type: none"> - An order, dated 07/01/24, to refer to podiatry. - An order, dated 07/23/24, for an appointment for foot and ankle, and staff made the appointment on 09/26/24. <p>F. On 07/24/24 at 2:38 pm, during an interview with the Unit Manager (UM), she stated R #65 was a diabetic, and her blood sugars were uncontrolled. She stated podiatry had not seen the resident yet. She stated she did not see a past appointment for R #65. She stated podiatry should see diabetic residents monthly. The UM stated she would expect podiatry to have seen R #65 since she was admitted in November 2023.</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>35632</p> <p>Based on observation and interview, the facility failed to put a resident in her bed when she was asleep, and the resident slumped forward in her wheelchair for 1 (R #13) of 1 (R #13) resident viewed during random observation. This deficient practice could likely cause the resident to fall forward out of her wheelchair and get hurt. The findings are:</p> <p>A. On 07/24/24 at 10:45 am, an observation of R #67 revealed the resident was asleep in her wheelchair in room off of the nursing station. She was slumped forward in her chair with one of her arms hanging off the side of the chair and appeared that she may fall out of the wheelchair.</p> <p>B. On 07/24/24 at 11:00 am, observation of R #67 revealed the resident slumped forward and asleep in her wheelchair. Certified Nursing Assistant (CNA) #5 and CNA #6 sat in the room with R #67, but neither CNA assisted R #67.</p> <p>C. On 07/24/24 at 11:03 am, during an interview and observation of CNA #5, the CNA did not answer any questions from the surveyor regarding R #67. CNA #5 got up and asked R #67 if she wanted to lay down in her bed. R #67 stated yes, she wanted to lay down.</p>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide and implement an infection prevention and control program.</p> <p>35632</p> <p>Based on observation, record review, and interview the facility failed to maintain proper infection prevention measures when the facility failed to ensure the shower bed was free of a hole and several other cuts that exposed the foam for 4 (R #21, 63, 67 and 201) of 4 (R # 21, 63, 67 and 201) residents that used the shower bed. Failure to replace items that required cleaning multiple times per day for infection control purposes could likely cause the spread of infections and illness to the residents who use the shower bed equipment. The findings are:</p> <p>A. On 07/22/24 at 2:02 pm, during an interview with R #67, she stated the shower bed she used for showers had a large hole in it, and it kept getting bigger. She stated it has been like that for months.</p> <p>B. On 07/24/24 at 10:55 am, during an observation of the shower room, the shower bed had multiple cracks on the shower bed mattress. The shower bed also had a large hole that went all the way through the mattress and exposed the pipe frame. The foam in the mattress was exposed in several places. The foam was a porous surface that absorbed water and any of other substance that touched it. It was not a smooth, washable surface.</p> <p>C. On 07/24/24 at 11:10 am, during an interview with Administrator, he stated he was not aware the shower bed had a large hole in the mattress. He stated there was only one shower bed for showering, and only a few residents used it.</p> <p>D. On 07/24/24 1:41 pm, during an interview with Certified Nursing Assistant (CNA) #5, she stated the shower bed has been like this for probably a couple of months. She stated management staff were aware of the issue with the shower bed. She stated it was hard to clean, because the foam was showing. The CNA stated they spray the shower chair down with an antibacterial spray and let it drip dry. She stated four or five residents used the shower bed.</p> <p>E. On 07/25/24 at 10:45 am, during an interview with R #63, he stated the shower bed was like that for three months. R #63 stated he used the shower bed a couple of times per week.</p> <p>F. On 07/25/24 at 10:50 am, during an interview with R #21, he stated he used the shower bed a couple of times per week. He stated he was not sure how long the hole in the shower bed had been there.</p> <p>G. On 07/25/24 at 10:55 am, during an interview with R #201, he stated he used the shower bed, and it was like that for at least one month. He stated he thought everyone was aware the bed had a hole.</p> <p>H. On 07/25/24 at 12:30 pm, during an interview with the Maintenance Director, he stated the shower mattress was reported to him by word of mouth and not through the system they typically used to report issues.</p>