

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 325071	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/10/2024
NAME OF PROVIDER OR SUPPLIER Aztec Healthcare		STREET ADDRESS, CITY, STATE, ZIP CODE 500 Care Lane Aztec, NM 87410	

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 0676</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35632</p> <p>Based on record review and interview, the facility failed to assist 1 (R #3) out of 3 (R #1, 2 and 3) residents reviewed for activities of daily living (ADLs; activities related to personal care such as bathing, showering, dressing, walking, toileting, and eating). This deficient practice could likely cause a resident to feel like they are a burden and embarrassed. The findings are:</p> <p>A. Record review of the face sheet for R #3 revealed the resident was admitted to the facility on [DATE] and discharged on [DATE]. The resident had the following diagnoses:</p> <ul style="list-style-type: none"> - Left lower foot amputation, - Type II diabetes (affects how your body uses insulin), - Circulatory issues (diseases that can affect your heart and blood vessels), - Diabetic neuropathy (type of nerve damage that can occur when you have diabetes), - Stomach cancer. - This is not an all inclusive list. <p>B. Record review of the admission Minimum Data Set (MDS; standardized, comprehensive assessment of an adult's functional, medical, psychosocial, and cognitive status) for R #3, dated 06/16/24, indicated the resident required partial, moderate assistance for toileting.</p> <p>C. Record review of the admission care plan for R #3, dated 05/14/24 to 07/17/24, revealed the care plan did not indicate R #3 was non-weight bearing with her legs.</p> <p>D. Record review of a grievance, dated 07/05/24, revealed R #3 reported to a staff member that she needed to go to the bathroom, and Certified Nursing Assistant (CNA) #2 told her to go in her brief. R #3 reported she did not want to do that.</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 0676</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>E. Record review of a written statement by CNA #2, dated 07/04/24, revealed CNA #2 stated she was told over and over that R #3 was a fall risk and non-weight bearing on her left foot. CNA #2 stated R #3 had difficulty with bowel movements in her wheelchair so I let her in bed so it's easier for her. This has been good for her. CNA #2 stated when R #3 mentioned she would have a bowel movement soon, CNA #2 told R #3 to let her know when she was finished.</p> <p>F. Record review of a written statement by CNA #4, dated 02/05/24, indicated she worked the same hall with CNA #2. She stated R #3 frequently asked to be transferred to the toilet, but she could not bear weight on her legs at all. CNA #4 stated staff usually changed R #3's brief or offered the resident a bed pan. She stated often R #3 will not void or defecate after staff transfer her to the toilet.</p> <p>G. On 09/09/24 at 2:31 pm, during an interview with Family Member (FM) #2, she stated the facility Administrator called her immediately after the incident, and the Administrator told her the CNA was suspended while they investigated the incident. FM #2 stated the Administrator verified the CNA told her mother to go to the bathroom in her brief.</p> <p>H. On 09/10/24 at 12:45 pm, during an interview with the Corporate Nurse (CN), she stated the Activities Assistant (AA) answered R #3's call light. The CN stated R #3 asked the AA if she would change her and then told the AA that CNA #4 told her to just go in her brief and she would change when she was done. The CN stated staff should provide R #3 the opportunity to go to the bathroom in the toilet. The CN stated it was hit and miss with R #3 using the toilet. The CN stated the resident had a partial foot amputation so there was a weight bearing issue on that foot, but the resident was not a non-weight bearing status. She stated the resident would use the toilet, and she would also use her brief. She stated staff should take residents who can get up to the toilet when they needed to go.</p> <p>The facility took corrective action immediately with CNA #2 and retrained all staff on 07/08/24. CNA #2 was also retrained on dignity and resident rights on 07/26/24. Due to the facility taking immediate correction action, the facility will be cited at past non-compliance. Facility was in compliance as of 07/26/24.</p> <ol style="list-style-type: none"> 1. The facility started an investigation into the incident after the grievance was submitted on 07/05/24. During the investigation, CNA #2 was suspended pending the results of the investigation. The outcome was for CNA #2 to be retrained on dignity and resident rights. 2. Record review of a corrective action memo, issued on 07/05/24 by Interim Director of Nursing (DON), indicated the allegations occurred and was a lack of dignity, against resident rights, and against their facility policy. 3. Record review of the employee education sign-in sheets, dated 07/08/24, for abuse and neglect, customer service, and care intervention indicated CNA #2 went to the training. 4. Record review of a training record, dated 07/26/24, indicated R #2 received dignity and privacy training. 5. Resident interviews were conducted with the residents residing on the same hall. Interviews did not identify any other resident who were told by staff to use the bathroom in their brief. 		