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 04/09/2026
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)
F 0578 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure advanced directives (code status; documents providing an individual's wishes for emergency and lifesaving care) were accurate within the Electronic Health Record (EHR) for 1 (R #21) of 2 (R #16 and #21) residents reviewed for advance directives, when: The facility failed to ensure R #21's advance directive forms and EHR contained matching and consistent information regarding the residents' end-of-life wishes.The facility staff did not update the resident's advanced directives in the EHR after the resident completed their Medical Orders for Scope of Treatment (MOST; a legal document which outlines the care the resident wants when they become incapacitated and unable to speak for themselves) form. The facility staff failed to honor R #21's do not resuscitate (DNR; lifesaving measures are not desired) status, performed cardiopulmonary resuscitation (CPR; an emergency procedure that combines chest compression with artificial ventilation) for 17 minutes, and attempted to use the automated external defibrillator (AED; a portable medical device designed to analyze a person's heart rhythm and deliver an electric shock if necessary) on the resident.If staff are not aware of a resident's code status, then staff may administer CPR and other life-saving interventions without the resident's consent or in contradiction to the resident's expressed wishes. The findings are: A. Record review of R #21's face sheet revealed R #21 was admitted into the facility on [DATE] with the following diagnoses: Encephalopathy (a degenerative brain disease that alters brain function or structure),Type 2 diabetes mellitus (DM2; a disease in which the body cannot make or properly use insulin),Shock (a life-threatening medical condition in which the body's organs and tissues do not receive enough blood flow, leading to oxygen deprivation and potential organ failure). B. Record review of R #21's baseline care plan, dated [DATE], revealed R #21's code status was not included in R #21's plan of care. C. Record review of R #21's MOST form, dated [DATE], revealed R #21's code status was do not resuscitate (DNR; lifesaving measures are not desired). D. Record review of R #21's nursing progress notes, dated [DATE] at 6:55 pm, revealed the following: Certified Nursing Assistant (CNA) entered R #21's room at 5:55 pm to deliver a dinner tray and observed R #21 unresponsive and sitting in his wheelchair. R #21 did not have a pulse or respirations (breathing). The nurse reported to R #21's room. Staff placed R #21 on the floor and initiated CPR.Staff called 911 and notified Emergency Medical Services (EMS). Facility nursing staff administered chest compressions. The facility nursing staff placed the AED pads on R #21, but the AED did not shock R #21. The facility nursing staff continued CPR until EMS arrived at 6:09 pm. EMS staff called a physician at a local hospital, and the physician called the time of R #21's death at 6:13 pm. E. On [DATE] at 12:41 pm, during an interview, the Director of Nursing (DON) stated it was the Social Services Directors' (SSD's) responsibility to ensure MOST forms are updated in the resident's EHR. F. On [DATE] at 12:52 pm, during an interview, the SSD stated the residents' MOST forms are uploaded into the residents' EHR after the MOST form was signed by the physician. The SSD stated a resident's MOST form and code status did not become active until a physician signed it. G. On [DATE] at 1:39 pm, during an interview, the Administrator (ADM) stated it was the expectation that all resident MOST forms were completed, and staff honored each resident's (continued on next page)

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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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aztec Healthcare	500 Care Lane Aztec, NM 87410

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F 0578 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	wishes regarding code status and treatment. H. On [DATE] at 3:49 pm, during an interview, Licensed Practical Nurse (LPN) #3 stated she initiated CPR on R #21 immediately after assessing R #21 and noted R #21 was not breathing and did not have a pulse. LPN #3 stated facility nursing staff transferred R #21 to the floor, she initiated CPR, and another staff member called 911. She stated additional facility nursing staff arrived and applied the AED to R #21. The facility nursing staff continued chest compressions and ventilations with an Ambu bag (a hand-held manual resuscitator used to provide positive-pressure ventilation to patients who are not breathing or are breathing inadequately). LPN #3 stated EMS arrived approximately 9 to 10 minutes after she initiated CPR on R #21. LPN #3 stated she reviewed R #21's top banner (banner across the front page of the EHR that contains important health related information for the resident) in the electronic health record and saw the resident's code status was a full code (lifesaving procedures desired). The LPN stated she did not review R #21's MOST form. LPN #3 stated nursing staff rely on an accurate top banner to determine a resident's code status. I. On [DATE] at 4:11 pm, during an interview, the Assistant Director of Nursing (ADON) stated the facility nursing staff should know each resident's code status in case of an emergency. The ADON said the residents' code status was located on the top banner in their EHR, and the MOST form was located in the documents section in the EHR. J. On [DATE] at 4:29 pm, during an interview, Certified Nursing Assistant (CNA) #4 stated staff communicated a resident's code status with each other, but a resident's code status should be accurate on the top banner in the EHR. K. On [DATE] at 4:39 pm, during an interview, CNA #5 stated she could locate a resident's code status on the top banner in the EHR, but she was unfamiliar with the MOST form. L. On [DATE] at 4:48 pm, during an interview, Registered Nurse (RN) #1 stated a resident's code status should be accurate on the top banner in the EHR and match the MOST form located in the EHR. M. On [DATE] at 6:15 pm, during an interview with the ADON and the Administrator, the ADON stated staff enter the resident's code status once they have a physician order. The MOST form may not be available to staff for a couple days while they waited for the physician to sign the MOST form. The ADON stated the MOST form became effective once it was signed by the physician. The Administrator confirmed the ADON's statement. Based on interviews and record review, an Immediate Jeopardy (IJ) was identified. The facility ADM was notified in person on [DATE] at 7:09 pm. The facility took corrective action by providing an acceptable Plan of Removal (POR). The POR was approved on [DATE] at 4:18 pm. Corrective action for affected resident:R #21 discharged from the facility on [DATE]. No corrective action can be taken.Actions taken to identify residents potentially affected by the deficient practice:Director of nursing or designee will complete a comprehensive advanced directive audit to verify the following:All current residents have been offered the opportunity to complete an advanced directive; Current residents who have formulated an advanced directive have a physician order for code status in the EHR that matches all resident's wishes on the current advanced directive as completed/signed by the resident/resident representative (RP).System Corrections:The administrator has implemented a process change wherein all licensed nurses are responsible to enter the physician order for a resident's code status consistent with the resident's advanced directive (MOST form).Director of nursing or designee will complete education with licensed nurses and social services director before the start of next scheduled shift regarding the process change and expectations for honoring a resident's right to execute an advanced directive and have the advanced directive followed as executed by the resident/RP, including:Social services director is responsible to inform resident or resident representative of their right to form an advanced directive and facilitate completion of the advanced directive (MOST form). The resident's code status request becomes valid when the resident/resident representative signs the advanced directive.The nurse is responsible to obtain and enter the physician order for the code status that matches the resident's wishes as directed on the advanced directive (MOST form) into the electronic health record on the date the MOST form was completed by the resident. This should be completed as soon as practicable after the resident/resident representative has signed the advanced directive.The social services director is (continued on next page)

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F 0578 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	responsible to ensure the code status order matches the MOST form and that the MOST form has been entered into the electronic medical record. This will be verified by the social services director or designee each time a new MOST form is executed.Administrator alleges removal of immediacy on [DATE]. Implementation of the POR was verified onsite on [DATE], and the IJ was removed on [DATE] at 6:59 pm. The scope and severity were reduced from a J to a G. Implementation of the POR was verified by the following:Record review of the facility's Quality Assurance and Performance Improvement Plan (QAPI; a structured framework used in healthcare to enhance the quality of care provided to patients) meeting minutes and Plan of Removal documentation dated [DATE] revealed the facility convened an ad hoc (when necessary or needed) QAPI meeting to review the Immediate Jeopardy related to advanced directives and code status accuracy. The review included the Administrator, Director of Nursing, Regional Nurse Consultant, and Medical Director, and addressed implementation of corrective actions to ensure resident advance directives were honored. Record review of the facility's Comprehensive Advance Directive audit dated [DATE] revealed the facility conducted a facility-wide audit of resident advance directives and corresponding code status orders. The audit identified multiple residents with discrepancies between the documented advance directives (including MOST forms) and physician orders for code status, as well as residents with missing or incomplete advance directive documentation.Record review of an in-service, dated [DATE] and titled Timely MOST and Code Status Order Entry, revealed the facility provided education to staff regarding the resident's right to formulate an advance directive and to have that directive honored. On [DATE] at 5:12 pm, during an interview, RN #2 stated he received training related to a resident's code status, where to locate a resident's code status, and the facility nursing staff is responsible to obtain and enter the physician order for the code status that matches the resident's wishes as directed on the MOST form when the resident completes it. On [DATE] at 5:14 pm, during an interview, the SSD stated she received training on the DNR status of the residents in the facility according to the POR, including when a resident's MOST form becomes effective upon completion by the resident. On [DATE] at 5:26 pm, during an interview, LPN #5 stated she had received training on the DNR status of the residents in the facility, including the facility nursing staff is responsible to obtain and enter the physician order for the code status that matches the resident's wishes as directed on the MOST form when the resident completes it. On [DATE] at 5:27 pm, during an interview, Housekeeper (HK) #1 stated he received education and training regarding resident advanced directives and MOST forms. On [DATE] at 5:38 pm, during an interview, the ADON stated she had received training on the DNR status of the residents in the facility, when the MOST form becomes effective, and updating the top banner in the EHR to match the resident's MOST form.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews, observations, and interviews, the facility failed to meet professional standards of practice for 2 (R #1 and R #2) of 2 (R #1 and R #2) residents, when: R #1 was administered oxygen (O2) without a physician's order. R #2 used a foley catheter (a thin, sterile tube inserted into the bladder to drain urine) without a physician's order. These deficient practices are likely to result in residents not maintaining their optimal health as planned by their medical provider. The findings are: R #1: A. Record review of the facility's Oxygen Administration Policy, dated 06/2020, revealed the following: A physician's order is required to initiate O2 therapy, The order should include the O2 flow rate, method of administration, usage of therapy, and indication for use. B. Record review of R #1's face sheet revealed R #1 was admitted into the facility on [DATE] with the following diagnoses: Malignant neoplasm of brain (cancerous tumor of the brain), Epilepsy (a seizure disorder). C. Record review of R #1's physician orders, dated 04/06/26, revealed an order for O2 use was not present. D. On 04/06/2026 at 1:43 PM, during an observation, an O2 concentrator (medical device delivering supplemental oxygen through a nasal cannula (a small, flexible tube that delivers oxygen to the nose through soft prongs) or a mask) was present in R #1's room. R #1 was observed lying in bed using O2 via a nasal cannula (NC). E. On 04/06/2026 at 3:59 PM, during an observation, R #1 was observed lying in bed using O2 via an NC. F. On 04/07/2026 at 3:34 PM, during an interview, the Assistant Director of Nursing (ADON) stated R #1 did not have physician's order for O2 use. She stated it was her expectation residents who require O2 have a physician orders for O2 use. G. On 04/07/26 at 4:21 PM, during an interview, the Director of Nursing (DON) stated it was his expectation all residents on O2 therapy have a physician order to administer the correct liter flow of O2. R #2:H. Record review of facility's Catheter Policy, dated 03/2020, revealed the following: Ensuring residents are not given indwelling catheters unless medically necessary, and unless there is valid medical justification, Residents receive the appropriate care and services to prevent infections to the extent possible. I. Record review of R #2' face sheet revealed R #2 was admitted into the facility on [DATE]. J. Record review of R #2's physician orders, dated 04/06/26, revealed an order for a foley catheter was not present. K. On 04/06/2026 at 1:29 PM, during an observation, a catheter collection bag (also called a drainage bag; a device connected to the catheter tubing and collects urine) was observed hanging from R #2's bed, indicating R #2 utilized a foley catheter. L. On 04/06/2026 at 1:36 PM, during an interview, Licensed Practical Nurse #1 (LPN) stated R #2 did not have a physician's order for a foley catheter. M. On 4/6/2026 at 4:27 PM, during an interview, the DON stated R #2 did not have a physician's order for foley catheter use. The DON stated if a resident does not have a physician's order for a foley catheter, the resident could develop complications in care.

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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. Based on observation, record review, and interviews, the facility failed to maintain an infection prevention and control program designed to provide a safe and sanitary environment (to prevent the development and transmission of communicable diseases and infections) for 1 (R #4) of 1(R #4) residents, when: The facility failed to follow the required Enhanced Barrier Precautions (EBP; an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employs targeted gown and glove use during high contact resident care activities) by not wearing appropriate personal protective equipment (PPE; protective clothing, face masks, goggles, or other garments or equipment designed to protect the wearer's body from injury or infection) when providing direct care to the resident.This deficient practice is likely to result in repeated and ongoing exposure of residents to increased risk of infection, cross-contamination, and injury. The findings are: A. Record review of the facility's Enhanced Precautions Infection Policy, dated 04/01/2024, revealed the following:To ensure the use of appropriate personal protective equipment to improve infection control as required in the care of residents,Designed to prevent transmission of multidrug-resistant organisms and employ targeted gown and glove use. B. Record review of R #4's face sheet revealed an admission date of 02/27/2023 with the following diagnoses: Peripheral vascular disease (PVD; poor circulation),Muscle weakness (reduction in the power exerted by muscles),Congestive heart failure (CHF; impaired heart function). C. Record review of R #4's Comprehensive Minimum Data Set (MDS; a federally mandated assessment instrument completed by facility staff), dated 03/06/2026, revealed the following: R #4 had an active diagnosis of a wound infection. D. Record review of R #4's physician orders, dated 01/20/26, revealed the following: Cleanse bilateral lower extremity (BLE; right and left lower leg), Cleanse lower legs with normal saline, apply Silvadene External Cream (a topical antimicrobial used to prevent and treat infections) 1% (percent), Wrap with kerlix gauze (100% cotton, prewashed, fluff-dried woven gauze designed for wound care) and report any changes if wound worsens. E. On 04/07/2026 at 9:01 AM, during an observation, signage was posted at the entrance of R #4's room indicating R #4 was on EBP and staff where required to wear PPE when providing care to R #4. F. On 04/07/2026 at 9:06 AM, during an observation, Certified Nursing Assistant (CNA) #1 was observed providing direct care to R #4 and not wearing PPE. G. On 04/07/2026 at 9:11 AM, during an interview, CNA #1 stated she was providing care to R #4 and was not wearing PPE. CNA #1 stated she should wear PPE when providing care to R #4. H. On 04/07/2026 at 9:33 AM, during an interview, the Director of Nursing (DON) stated it is his expectation all staff providing care follow the EBP guidelines. The DON stated if staff do not follow the required EBP, transmission of infection could occur.