STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	325071	A. Building B. Wing	06/07/2024

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. 48645 Based observation, record review, and interview the facility failed to have the Interdisciplinary Team (IDT; a facility team composed of various professionals who review and determine resident needs and abilities) determine if residents could self-administer medication for 1 (R #73) of 1 (R #73) residents randomly sampled. This deficient practice is likely to result in residents self-administering medication inappropriately or incorrectly which could cause harm. The findings are: A. Record review of R #73's care plan, dated 05/05/24, revealed the plan did not state the resident could self-administer medication. B. Record review of R #73's active physician's orders, as of 06/04/24, revealed the resident did not have an order for self-administering medications. C. On 06/04/24 at 8:55 am, during an observation, R #73 ate her breakfast while lying in bed. R #73 took a medication cup with five tablets in it and swallowed the medication one at a time. Further observation revealed staff members were not present inside the resident's room or outside her door. D. On 06/04/24 at 9:00 am, during an interview with R #73, she stated she liked to take her morning medications after she ate, and the staff member left them with her to take after she finished eating. R #73 further stated she needed to take her medications one at a time, because she choked on them if she took them all together. E. On 06/05/24 at 12:06 pm, during an interview with the Director of Nursing (DON), she stated that if a resident was allowed to administer their own medications, then it would be documented in the resident's physician orders and care plan. The DON stated R #73's physician's orders and care plan did not contain the information, and the resident was not allowed to administer her own medications. The DON further stated it was expected for staff to observe the resident take medications and not to leave the medication with the resident.

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47899 Based on interview and record review the facility failed to keep residents free from abuse for 4 (R #27, R #28, R #56 and R #134) of 5 (R #20, R #27, R # 28, R #54 and R #134) residents reviewed for abuse when staff failed to: 1. Prevent emotional trauma as a result of not immediately removing the deceased body of R #27's roommate or moving R #27 from the room while waiting for the funeral home. 2. Physical abuse by the same Certified Nurse Aide (CNA) for R #27, 38, 56, and 134. The findings are: Findings for R #27 A. Record review of R #27's face sheet, dated [DATE], revealed she was admitted to the facility on [DATE] for multiple diagnoses including but not limited to: - Need for assistance with personal care. - Lack of coordination. - Morbid obesity (severe) due to excess calories (imbalance between the number of calories consumed and the number of calories burned). B. Record review of R #27's quarterly Minimum Data Set (MDS; a federally mandated assessment instrument completed by facility staff), dated [DATE], revealed the resident had a Brief Interview for Mental Status (BIMS; a screening for cognitive impairment. Scores range from 00 to 15) score of 15, cognitively intact. C. On [DATE] at 1:55 pm during an interview, R #27 stated she was R #136's roommate since [DATE]. She stated her roommate (R #136) passed away on [DATE], and staff left her in the room with the body. R #27 stated she asked staff to move the body, but they did not. She stated an unknown CNA stood behind the privacy curtain, told her Rest in peace, [Name of R #27], turned off the light, walked out of the room, and shut the door. She stated since that day she had panic attacks and did not want another roommate. She stated she was scared and had anxiety about being in a room with another deceased roommate. R #27 revealed she told the Assistant Director of Nursing (ADON) about the incident, but she did not receive a response from the ADON. D. Record review of a nursing progress note for R #136, dated [DATE], revealed R #136 passed away on [DATE] at 1:24 am, and the body was removed from the room at 3:00 am. E. On [DATE] at 11:49 am, during an interview, the Assistant Director of Nursing (ADON) confirmed R #136 was deceased and left in R #27's room from 1:24 am to 3:00 am. The ADON stated she did not believe it to be best practice to leave a resident in the room with a deceased roommate. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Findings related to CNA #4 R #134 F. Record review of R #134 face sheet, dated [DATE], revealed she was admitted to the facility on [DATE] with multiple diagnoses including, but not limited to: - Malignant neoplasm of unspecified site of unspecified female breast (breast cancer). - Type 2 diabetes with diabetic neuropathy (nerve damage that develops gradually and caused by long-term high blood sugar levels). - Muscle weakness. - Unsteadiness on feet. - Need for assistance with personal care. - Dependence on dialysis (a blood purifying treatment given when kidney function is not optimum). - Lack of coordination. G. Record review of the facility incident report, dated [DATE], revealed R #134 reported CNA #4 entered her room, kicked her on her lower leg, and hit her kidney to wake her up on [DATE] around 8:30 pm. R #134 stated she was unsure if she wanted to report it. There were no injuries noted. H. On [DATE] at 11:49 am, during an interview with the ADON, she stated CNA #4 was suspended pending investigation on [DATE] with a return date of [DATE]. I. Record review of Corrective Action Memo for CNA #4, dated [DATE], revealed CNA #4 reported she attempted to wake R #134 several times, but R #134 did not wake up. CNA #4 reported she tapped the resident on the shoulder, and it startled the resident. J. Record review of the facility's In-Service Training for Abuse/Neglect training, dated [DATE], and the facility's Customer Service/Care Interaction training, dated [DATE], revealed CNA #4 was in attendance. R #28 K. Record review for R #28's face sheet, dated [DATE], revealed she was admitted to the facility on [DATE] with multiple diagnoses including but not limited to: - Parkinson, unspecified (not a single disease, but a term for a group of conditions that affect movement and mimics Parkinson disease). - Chronic respiratory failure with hypoxia (an ongoing condition that affects your ability to breathe and process oxygen). (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	- Need for assistance with personal care. - Other dysphasia (trouble swallowing). - Unsteadiness on feet. - Morbid obesity due to excess calories (imbalance between the number of calories consumed and the number of calories burned). - Rheumatoid arthritis, unspecified (chronic inflammatory disease that affects the joints). - Depression (feeling of sadness). L. Record review of a grievance report for R #28, dated [DATE], revealed the resident stated the night before [[DATE] thru [DATE]] was the worst night she ever had. R #28 reported CNA #4 yelled at her and told her to stay off the call light. R #28 stated CNA #4 said she would return to help her. R #28 stated CNA #4 shoved her, was very aggressive, and hurt her when she (CNA #4) changed her. M. On [DATE] at 1:17 pm, during an interview, R #28 stated a female staff was rough with her during care, but she was unable to recall the CNA's name. She stated the CNA worked nights. R #28 stated she had bruises from the CNA. She stated the police came and took a report from her. She stated she knew the CNA was fired. R #28 stated she felt like the call light was there so she could get help, not to make her feel like a problem. N. Record review of the staff schedule, dated [DATE], showed CNA #4 worked on R #28's unit on [DATE] during the 7:00 pm to 7:00 am shift. O. Record review of timecard for CNA #4 revealed the last shift she worked at the facility was the evening shift on [DATE] at 6:02 pm until morning of [DATE] at 6:01 am. P. Record review of the Police Department Field Case Report, dated [DATE], revealed the following: - Name of CNA #4. - Name victim: R #28. - Officer received a report from R #28, She advised she was resting in bed. She stated the CNA (her name) told her to keep off her call light. When the CNA #4 came to turn her, she shoved her over to the side very roughly. - During an interview, R #28 told the Officer, [Name of CNA #4] was in a bad mood. She yelled at me for using the call light. R #28 told the Officer that CNA #4 was very aggressive and rough with her when she (CNA #4) came to turn her (R #28). The resident stated the CNA shoved her to the point it caused bruising and pain. Q. Record review of the Police Department Field Case Supplement, dated [DATE] revealed the following: (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	- R #28 stated she pressed her call light throughout the shift, and it upset CNA #4. The resident stated CNA #4 started to yell and scream at her and told her not to press her call light button. R #28 told the Officer CNA #4 shoved her when she (CNA #4) changed her (R #28). The resident showed the Officer how it occurred with her hand, in a palm strike type manner. R #28 stated CNA #4 hit/shoved R #28's right leg, and it was so hard it caused her leg to hit her other leg. - R #28 showed the officer her right outer thigh, and a large amount of bruising was noted on her leg. It covered approximately seven inches in length, along with multiple inches wide. - R #28 showed the officer her left inner leg, and the officer observed a lot of bruising. - R #28 stated CNA #4 caused the bruising. - There were two photographs of the right leg bruising and left leg bruising. R. Record review of the Police Department Field Case, Supplemental Narrative, dated [DATE], revealed an arrest warrant was obtained for CNA #4 for one count of battery (the unlawful application of physical force to another person without their consent). S. On [DATE] at 11:49 am, during an interview with the ADON, she stated they suspended CNA #4 pending investigation when the incident was reported on [DATE], and they terminated CNA #4's employment at the facility on [DATE]. T. On [DATE] at 11:31 am, during an interview with Director of Nursing (DON), she stated CNA #4 came back to work on [DATE] and was placed on the 200 hall. She stated, that after CNA #4 returned, a staff member reported to her (the DON) that R #28 voiced concerns about the CNA. The DON stated she spoke with R #28, and the resident told her about the terrible night she had with CNA #4. She stated R #28 reported CNA #4 scolded her for using her call light too many times, and when CNA #4 turned her, she (CNA #4) shoved her (R #28) on her hip area. The DON stated staff assessed R #28 and filed a grievance form. She stated during R #28's assessment, staff noted slight bruising on the resident's right side hip area. The DON stated she immediately suspended CNA #4 again, and staff did a skin sweep on the hall that CNA #4 worked. The DON stated that was when they found the bruising on R #56. R # 56 U. Record review of R #56's face sheet, dated [DATE], revealed she was admitted to the facility on [DATE] with multiple diagnoses that including but not limited to: - Fracture of the neck right femur (broken hip). - Adult failure to thrive (a condition that affects appetite, weight, and activity). - Need for assistance with personal care. - Unspecified dementia, unspecified severity, with psychotic disturbance (caused by damage to or loss of nerve cells and their connections in the brain). (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	- Muscle wasting and atrophy, not elsewhere classified, multiple sites (loss of muscle leading to its shrinking and weakening). - Other symptoms and signs involving cognitive functions and awareness (difficulty in understanding or making sense of one's surroundings). V. Record review of a Shower Sheet for R #56, dated [DATE], did not identify any skin injury. W. Record review of Change in Condition Evaluation for R #56, dated [DATE], revealed resident had swelling with purple/black discoloration to her right lower arm. X. Record review of nursing progress notes for R #56, dated [DATE], revealed the resident was sent out for a right arm x-ray due to suspicion of a fracture. Y. Record review of the Diagnostic Radiology Report for R #56, dated [DATE], revealed the following: - Reason for exam: bruising and swelling of right forearm. - No fractures or dislocation. Z. Record review of the Police Department Case Report, dated [DATE], revealed: - R #56 had major bruising and trauma to her right forearm, on or around [DATE] [sic]. R #56 did not have any injuries prior to receiving care from CNA #4, and CNA #4 was the only staff who cared for the resident on [DATE] [sic]. Additionally, there was not an obvious medical cause for the injury, no blood drawn, and R #56 did not have any clotting disorders or medical conditions which would cause her to bruise spontaneously. - Pictures were part of the file and showed bruising of the resident's right forearm, with a visible bump to the right forearm. - According to the detective, the injuries on R #56 appeared to be consistent with her arm having been grabbed aggressively. AA. On [DATE] at 10:24 am during interview with the Regional Nurse Consultant (RNC), she confirmed the last time CNA #4 worked at the building was the evening of [DATE] thru the morning of [DATE]. The RNC stated R #56 had skin discoloration on [DATE], and the Physician felt the injury was latent (existing but not yet developed) in showing bruising. She also stated CNA #4 worked with R #56 independently on the evening shift of [DATE]. She stated the CNAs worked in pairs the evening of [DATE], and they did not report any incident of falls or other concerns, as it related to the bruising on R #56's arm. The RNC stated they felt that it was very likely that CNA #4 also hurt R #56, due to the other allegations/injury identified with R #28.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 35632 Based on record review and interview, the facility staff failed to report incidents to the State Agency (SA) in which the management received an allegation of employee-to-resident abuse/neglect and submit a five day follow-up report (a report detailing the facility's investigation, conclusion, and corrections for incidents reported to the SA) for 5 residents (R #28, #45, #56, #133, and #134) of 7 (R #20, #27, #28, #45, #56, #133 and #134) residents reviewed for abuse. If the facility fails to report incidents and follow-ups to the SA, then it could likely impact the safety and well-being of the residents. The findings are: Resident #133 A. Record review of the nursing progress notes for R #133, dated on 01/08/24, indicated Nurse #7 informed Nurse #8 she could not find R #133 in the facility. Nurse #8 notified the Assistant Director of Nursing (ADON) that R #133 was missing for several hours. R #133 entered the facility smelling of alcohol. A blood alcohol content (BAC; a test to determine the amount of alcohol in a person's bloodstream. A blood alcohol content of 0.08% or greater would indicate legally intoxicated) was completed, and R #133 had a BAC of 0.209%. B. On 06/05/24 at 11:37 am, during an interview with the Assistant Director of Nursing (ADON), she stated staff notified her R #133 was intoxicated. She stated she also received a report of concerns that Certified Nursing Assistant (CNA) #4 and CNA #5 drank alcohol and smoked cigarettes with R #133 during the night shift (when the resident had a BAC of 0.209%). The ADON stated staff reported to her that R #133, CNA's #4, and CNA #5 hung out in one of the CNA's car off and on all evening. She stated R #133 did not tell her where he got the alcohol. The ADON stated they discharged R #133 from the facility and suspended CNA #4 and CNA #5. The ADON stated she did not know why she did not report the incident to the SA. 47899 Resident #134 C. Record review of the facility's incident report, dated 03/04/24, showed the facility reported an incident to the SA regarding CNA #4 and R #134, but they did not submit the five day follow-up investigation. Resident #28 D. Record review of the health facility incident report, dated 03/08/24, showed the facility reported an incident to the SA regarding CNA #4 and R #28, but they did not submit the five day follow-up investigation. Resident #56 (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	D. Record review of the health facility incident report, dated 03/08/24, showed the facility reported an incident to the SA regarding CNA #4 and R #56, but they did not submit the five day follow-up investigation. 48645 Resident #45 E. Record review of the health facility incident report, dated 04/15/24, showed the facility reported an incident to the SA regarding CNA #2 and R #45, but they did not submit the 5 day follow-up investigation. F. On 06/05/24 at 11:49 am and 12:25 pm, during an interview with the ADON, she stated she sent the five day follow-up investigations to the SA via the online reporting system, but she did not realize there was an error which did not allow them to be transmitted.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47899 Based on record review and interview, the facility failed to develop a comprehensive, person-centered plan which included information about fall interventions used for 1 (R #14) of 1 (R #14) residents reviewed for care plans. This deficient practice could likely result in residents not receiving the care needed to reach their highest practicable level of wellbeing. The findings are: A. Record review for R #14's face sheet, dated 06/04/24, revealed she was admitted to the facility on [DATE] for multiple diagnoses including but not limited to: - Cerebral infarction due to thrombosis of right posterior cerebral artery (Stroke due to a blood clot). - Abnormal posture (refers to rigid body movements and chronic abnormal positions of the body). - Unsteadiness on feet. - Muscle weakness. - Pain, unspecified. - Wedge compression fracture of T9 T10 vertebra (a type of compression fracture that occurs when one side of your vertebrae collapses and creates a wedge shape). - Wedge encounter compression fracture of T9 T10 vertebra (a type of compression fracture that occurs when one side of your vertebrae collapses and creates a wedge shape). B. On 06/04/24 at 10:46 am, during an observation, R #14 sat in her room in her wheelchair and fall mats were on the floor. C. On 06/06/24 at 12:30 pm, during an observation of R #14's room, two fully opened fall mats were on the floor. D. Record review of R #14's care plan, dated 02/13/24, revealed the care plan did not address the resident's use of fall mats as an intervention for falls. E. On 06/07/24 at 8:46 am, during an interview with the Assistant Director of Nursing (ADON), she stated staff leave the fall mats on the floor even when R #14 was out of bed. She stated the mats prevented the resident from receiving an injury from a fall. F. On 06/07/24 at 8:49 am during an interview, the Director of Nursing (DON) stated staff did not document the use of fall mats in R #14's care plan.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. 35632 Based on record review and interview, the facility failed to meet professional standards of quality for any of the residents who resided on 100, 200 hallways.This deficient practice could cause any of the residents on those two hallways to not have their needs met, which could cause issues like skin breakdown, infections, falls, and dehydration. The findings are: A. Record review of the nursing progress notes for R #133, dated on 01/08/24, indicated Nurse #7 informed Nurse #8 she could not find R #133 in the facility. Nurse #8 notified the Assistant Director of Nursing (ADON) that R #133 was missing for several hours. R #133 entered the facility smelling of alcohol. A blood alcohol content (BAC; a test to determine the amount of alcohol in a person's bloodstream. A blood alcohol content of 0.08% or greater would indicate legally intoxicated) was completed, and R #133 had a BAC of 0.209%. Nurse #8 also notified the Assistant Director of Nursing (ADON) that Certified Nursing Assistant (CNA) #5 was missing for several hours. B. Record review of a statement by CNA #8, dated 01/08/24, revealed CNA #8 worked the night shift that evening/night on 01/07/24 to 01/08/24. The statement revealed around 10 pm we noticed both girls (CNA #4 and #5) missing after multiple call lights had gone off for a significant time. The statement revealed hours passed between the times CNA #8 saw either CNA. The statement also revealed CNA #8 received a text message on his phone around 3:01 am from CNA #4 that stated let us know when our lights goes off. CNA #8 documented the CNAs returned a short time later, did rounds, and went home. C. Record review of a statement made by Nurse #7, dated 01/08/24, revealed CNA #5, CNA #4, and R #133 went in and out of the facility all night and sat in one of their cars, with the music blasting during the the night shift on 01/07/24 to 01/08/24. Nurse #7 stated she went to one of the CNA's car window after a couple hours, but the CNAs ignored her and turned the music up. Nurse #7 documented CNA #4 was upset at her for knocking on the car window, and CNA #4 told her you have no right coming to my car. The statement revealed Nurse #7 informed CNA #4 that she (Nurse #7) was the charge nurse and had the right to tell them something. The statement also revealed the other CNAs working that evening answered call lights on CNA #4's and CNA #5's hallways. D. Record review of a statement made by CNA #9, dated 01/08/24, revealed CNA #9 witnessed CNA #5 and CNA #4 take a two-and-a-half hour break and then go out to their cars for another hour, during the night shift on 01/07/24 to 01/08/24. The statement revealed the charge nurse went out to their car and knocked on their windows, but they ignored her. CNA #9 documented CNA #4 and #5 then left shift at 4:45 am. E. On 06/04/24 at 6:24 pm during an interview with CNA #5, she stated she and CNA #4 took at least five or six smoke breaks on the night shift on 01/07/24 to 01/08/24. She stated it was cold that night so they sat in CNA #4's car. She stated they were just smoking when R #133 came out and invited himself into the car. CNA #5 said R #133 seemed pretty out of it already. She stated Nurse #7 came out and knocked on the window. She stated CNA #4 got mad at the nurse, and they never rolled down the window. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	F. On 06/05/24 at 7:48 am during an interview with Nurse #7, she stated CNA #5 and CNA #4 did not work their floor most of the night on the night shift on 01/07/24 to 01/08/24. She stated they sat outside in one of their cars and smoked. She stated there was a concern they were also drinking alcohol. She stated she confronted the CNAs in their car by knocking on the window, but they ignored her and turned up their music. She stated the other CNAs working that night witnessed the incident, and they were very frustrated. She stated the CNAs were gone for three hours at one point. Nurse #7 stated she felt the CNAs abandoned their job. She stated she spoke with day nurse, and it was reported to ADON. G. On 06/05/24 at 11:37 am, during an interview with the ADON, she stated she found out at 6:00 am on 01/08/24 what happened that evening. She said the night nurse reported it to the day nurse, and the day nurse reported it to her. She stated they tested R #133's BAC, and he was intoxicated. The ADON stated the resident would not say where he got the alcohol. The ADON stated she had CNA #5 and CNA #4 come in and give statements, and she suspended CNA #5 and CNA #4 after she got the statements from the CNAs and staff members working on the night shift on 01/07/24 to 01/08/24. She stated the CNAs sat outside in their car smoking, and they hung out with the resident. She stated the two CNAs told her they were outside at least six times that evening, but it was not clear how long they were outside. H. On 06/06/24 at 10:13 am, during an interview with CNA #10, she stated she worked the dayshift on 01/08/24. CNA #10 stated that when she came that morning for her shift, her residents had not been taken care of. She stated some of them were soaking wet, but she could not recall which residents. She stated at least half the residents on her hall needed something when she started her shift. She stated the sheets on a few of the residents' beds had urine rings from multiple incontinent episodes, and some of the residents had a brief that was soaked through.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	325071	A. Building B. Wing	06/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aztec Healthcare	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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47899 Based on observation, interview and record review, the facility failed to keep residents free from accidents for 2 (R #14 and R #58) of 2 (R #14 and R #58) residents reviewed when staff failed to: 1. Ensure R #14's fall mat (a safety feature placed along the side of the bed to prevent injury) was picked up when the resident was not in bed. 2. Ensure staff checked placement of the wanderguard for R #58. These deficient practices could likely result injury or death to residents due to tripping on the floor mats and eloping from the facility. The findings are: A. Record review for R #14's face sheet, dated 06/04/24, revealed she was admitted to the facility on [DATE] for multiple diagnoses including but not limited to: - Cerebral infarction due to thrombosis of right posterior cerebral artery (Stroke due to a blood clot). - Abnormal posture (rigid body movements and chronic abnormal positions of the body). - Unsteadiness on feet. - Muscle weakness. - Pain, unspecified. - Wedge compression fracture of T9 T10 vertebra (a type of compression fracture that occurs when one side of your vertebrae collapses and creates a wedge shape). - Wedge encounter compression fracture of T9 T10 vertebra. (a type of compression fracture that occurs when one side of your vertebrae collapses and creates a wedge shape). B. On 06/04/24 at 10:46 am, during an observation and interview, R #14 sat in her room in her wheelchair and fall mats were on the floor. She stated she could not move around in her room due to the mats on the floor. R #14 pointed to the fall mats on the floor. She stated, They are in the way all the time. I can't move in here. They hang me up. C. On 06/06/24 at 12:30 pm, during an observation of R #14's room, two fully opened fall mats were on the floor. R #14 sat in her wheelchair and was not in her bed. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	325071	A. Building B. Wing	06/07/2024

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	D. On 06/07/24 at 8:46 am, during an interview with the Assistant Director of Nursing (ADON), she stated staff leave the fall mats on the floor even when R #14 was out of bed. She stated it would prevent an injury from a fall, but she never thought about it being a fall hazard. 35632 E. On 06/03/24 at 1:30 pm, an observation revealed a staff member watched and observed R #58. F. On 06/03/24 at 1:30 pm, during an interview with hospitality aide #1, she stated she was currently on a one-to-one (one person monitoring another person) with R #58. She stated she tried to stay away from the resident, because he can become agitated. G. Record review of the annual Minimum Data Set (MDS; a federally mandated assessment instrument completed by facility staff) for R #58, dated 03/27/24, revealed a Brief Interview for Mental Status (BIMS; a screening for cognitive impairment. Scores range from 00 to 15) score of 7, severe cognitive impairment. H. Record review of the nursing progress note for R #58, dated 5/4/24, indicated R #58 told an unknown Certified Nursing Assistant (CNA) he was packing his belongings, because he wanted to leave the facility. Staff notified the ADON and placed a wanderguard on the resident's right leg. I. Record review of the physician orders for R #58 indicated an order, dated 05/05/24, to check wander guard placement to right ankle and function, every shift, two times a day for elopement (leaving without others knowledge). J. Record review of the elopement evaluation for R #58, dated 05/06/24, indicated the resident scored a 15, imminent (high) risk of elopement. K. Record review of the nursing progress note for R #58, dated 06/02/24 at 2:39 am, indicated R#58, left the facility with a visitor of a different unknown resident on 06/01/24. The visitor took R #58 to his home in Arizona and dropped him off. Facility staff were not aware R #58 was not at the facility until dinner time when they were not able to locate him. Facility staff located the resident and picked him up. The resident returned to the facility and was unharmed. L. On 06/05/24 at 11:37 am, during an interview with ADON, she stated she saw the order for a wanderguard and to check placement, dated 05/05/24. She stated R #58 would not let facility staff check the placement of his wanderguard, so that was not done. She stated the resident must have taken the wanderguard off at some point, because he did not have one on when he eloped on 06/01/24.