STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	325074	A. Building B. Wing	06/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Good Samaritan Society - Manzano Del Sol	5201 Roma Avenue NE Albuquerque, NM 87108

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 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35632 Based on record review and interview, the facility failed to provide quality of care for 1 (R #1) of 1 (R #1) resident reviewed for dehydration and nutrition when: 1. Staff failed to identify the decrease in nutritional intake and weight loss for R #1 as a change in condition. 2. Staff delayed to send R #1 to the hospital for two days after significant change in vitals. These deficient practices likely resulted in R #1's admission to the hospital with dehydration, urinary tract infection and sepsis (severe infection). The findings are: A. Record review of R #1's face sheet indicated she was admitted on [DATE] with the following diagnoses: - Fetal alcohol syndrome (condition in a child that results from alcohol exposure during the mother's pregnancy), - Severe intellectual disabilities [intelligence quotient (IQ) below 70 and deficits in at least two adaptive behaviors that affect everyday, general living], - Urinary tract infection, - Retention of urine (not fully draining urine from your bladder), - Dysphagia (difficulty swallowing). - This is not all inclusive list of diagnoses. B. Record review of the physician's orders for R #1 revealed the following, an order for house supplement (nutritional drink which includes carbohydrates, protein, fat, vitamins, and minerals and meant to provide a boost of nutrition to someone who is unable to get what they need from regular eating) four times a day for poor intake start date 01/26/24; and to weigh every Tuesday in the morning start date 04/23/24. (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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F 0684 Level of Harm - Actual harm Residents Affected - Few	C. Record review of the nursing progress notes for R #1, dated 04/12/24, indicated R #1 did not eat or drink much. On admission to the facility, staff had a conversation with the resident's Guardian (a person who is legally responsible for the care of another person) about hospice. Staff entered an order on 04/12/24 for hospice to evaluate R #1 since the resident declined over the past several months and continued to decline. D. Record review of a progress note for R #1 written by the Registered Dietician, dated 04/12/24, revealed R #1's weight was 143 pounds. Significant weight gain of 8 pounds (5.9%) in 1 day, likely due to inaccuracy. Weight fluctuated but trending decline. Close to weight at admission. Average intake 40 percent (%) with recent decline to below 25%. House supplement four times per day at 85% intake. Continue current plan of care. Continue weekly weight and referral to hospice. E. Record review of a nutritional progress note written by the Registered Dietician (RD) for R #1, dated 04/19/24, indicated the resident weighed 136 pounds (lbs), which was a 10 lb weight loss in 30 days. The resident's average intake was around 35 percent (%). The resident received a house supplement four times a day, and her intake averaged 95%. The resident is dependent on staff and required eating assistance She also required encouragement and supervision during and between mealtime for fluid, food, and snacks. F. Record review of the care plan for R #1, indicated the following care plan items: - R #1 had a communication problem due to a weak and absent voice, rarely or never understood, and rarely or never understands. - Initiated date 04/26/24, R #1 should be up in a wheelchair and in the dining room for all meals. The care plan directed staff to monitor weights weekly, poor intakes during meals, hydration, and supplements. - Acitivities of daily living (ADL) - R #1 was totally dependent on facility staff for bathing, bed mobility, dressing, eating, and personal hygiene. - R #1 had bladder incontinence, urinary retention, and recurrent urinary tract infections. - Monitor fluid intakes and for urinary tract infection (UTI) such as pain, burning, blood tinged urine, cloudiness, no output, urine color, change in eating, mental status and vitals. G. Record review of the Medication Administration Record (MAR) for R #1, dated 05/01/24 to 05/10/24, indicated staff documented the following: - Staff gave the resident 40 supplements. - R #1 drank 100 percent (%) of 22 of them. - R #1 drank 50% of 9 of them - R #1 drank 25% or less of 9 of them. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	H. Record review of the meal consumption percentages for R #1 indicated staff documented the following: - 05/14/24, one meal at 0-25%. - 05/13/24, two meals at 0-25%. - 05/12/24, one meal refused and two meals at 0-25%. - 05/11/24, one meal at 0-25% and one meal at 26-50%. - 05/10/24, one meal at 0-25% and one meal at 26-50%. - 05/09/24, one meal at 0-25% and one meal at 51-75%. - 05/08/24, one meal at 0-25% and one meal at 51-75%. - 05/07/24, two meals at 0-25%. - 05/06/24, staff did not document the resident's consumption percentages. - 05/05/24, one meal documented at 0-25%. - 05/04/24, one meal at 26- 51% and one meal at 76-100%. - 05/03/24, one meal at 51-76% and two meals at 76-100%. - 05/02/24, two meals at 76-100%. - 05/01/24, two meals at 76-100%. - 04/30/24, one meal at 0-25%. I. Record review of the daily, total fluid consumption percentage during meals and supplements for R #1 indicated staff documented the following: (The average woman should drink between 91 and 95 ounces per day of water/fluid): - 05/14/24, for two meals 960 cc / 32.5 ounces (oz). - 05/13/24, for one meal 80 cc / 2.70 oz. - 05/12/24, for two meals 960 cc / 32.5 oz. - 05/11/24, for two meals 900 cc / 34.93 oz. - 05/10/24, for two meals 1080 cc / 36.51 oz. - 05/09/24, for three meals 1200 cc / 40.56 oz. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	- 05/08/24, for two meals 360 cc / 12.17 oz. - 05/07/24, for two meals 240 cc / 8.11 oz. - 05/06/24, staff did not document the resident's consumption percentages. - 05/05/24, for one meal 200 cc / 6.76 oz. - 05/04/24, for two meals 760 cc / 25.69 oz. - 05/03/24, for two meals 960 cc / 32.5 oz. - 05/02/24, for two meals 960 cc / 32.5 oz. - 05/01/24, for two meals 960 cc / 32.5 oz. - 04/30/24, for one meal 480 cc / 16.23 oz. J. Record review of weights in the electronic medical record for R #1 indicated the resident weighed the following: - On 05/09/24, 125.0 lbs. - On 05/07/24, 127.0 lbs. - On 04/30/24, 140.0 lbs. - On 04/19/24, 143.0 lbs. - On 04/15/24, 136.0 lbs. K. Record review of the nursing progress notes for R #1 indicated the following: - On 05/10/24, staff called the resident's guardian. The resident had significant (a greater than 5% weight loss in 30 days) weight loss of 13 lbs (9.3% body weight loss) in a week. Resident recently started pocketing food and drink (where food is held in the mouth, especially in the cheeks, without being swallowed), and she had an average food intake of less than 25% in the past week. Supplement intakes two weeks ago were at 95% but declined to ~ 65% this week. Will collaborate with nursing, Speech-Language Pathology (SLP), and dietary department to offer additional supplements and snacks. The resident likes root beer. Staff should offer supplement with root beer, additional root beer float , additional supplement, and boost pudding (nutritional supplement in a pudding format) or magic cup (nutritional supplement in a frozen format) when available would be beneficial. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	- On 05/12/24, Certified Nursing Assistant (CNA) reported to the nurse on-call that the resident was warm to touch. Staff took the resident's vital signs on 05/12/24 at 9:36 pm, and they were as follows: Blood pressure (BP; normal blood pressure for adults ages 20 and older is 120/80): 123/68, heart rate [HR; normal heart rate in an individual is 60 to 100 beats per minute (bpm)]: 138 bpm, respiration rate (RR; rate of breathing. Normal RR 16 to 20 breaths per minute): 37, oxygen saturation (O2 sat; measure of how much oxygen is traveling through your body in your red blood cells. Normal O2 sat is between 95% and 100%): 79 to 85% room air (RA), temperature [temp; normal temperature for adults is in the range of 97 degrees ( ) Fahrenheit (F) to 99 F]: 100.5 F. The resident's urine appeared to have some blood clots and sediments. The resident's skin was warm to touch and was clammy. Staff removed all blankets off the resident and placed supplemental oxygen via nasal cannula (NC; medical device to provide supplemental oxygen therapy to people who have lower oxygen level) at 4 liters per minute (L/min) via NC. Staff attempted to give the resident her scheduled medications, including Tylenol, to decrease elevated temperature; however, resident did not swallow the medication. The resident kept her mouth open and did not listen to verbal instructions. In order to prevent the resident from choking or aspirating (to breathe in or to breathe a substance into your lungs by accident), staff cleaned the resident's mouth with a toothette (disposable, single-use sponges attached to a stick and used for oral care) to remove medication mixed with yogurt. L. Record Review of the physician orders for R #1, dated 05/14/24, indicated an order to transfer R #1 to hospital immediately for possible sepsis (serious infection). Patient had a fever yesterday, and now she had tachycardia (increased heart rate), hypoxia (low oxygen), hypernatremia (having too much sodium in the blood), acute kidney injury (AKI; a sudden decrease in kidney function that develops rapidly over a few hours or days. It may be fatal.), and hyperglycemia (high blood sugar). M On 06/18/24 at 12:30 pm during interview with Nurse Practitioner (NP), she stated she was aware of R #1's condition on 05/13/24. She stated the on-call physician made the decision not to send the resident to the emergency room and placed orders for an IV, labwork, and antibiotics instead. She stated R #1's vitals were more stable later when she came to see R #1 on the 05/13/24, and she wanted to wait to see what the lab work indicated. The NP stated the resident's lab work came back on 05/14/24. She said the resident's vitals were not stable on 05/14/24, and the lab results indicated the resident had high neutrophils (white blood cells; if high it may be due to medical conditions like infection.) The NP stated she decided to send R #1 out to the hospital. She stated she probably should have sent R #1 out to the hospital sooner. N. On 06/17/24 at 12:37 pm, during an interview with the Tribal Services Guardian, she stated R #1 was malnourished and dehydrated when she was admitted to the hospital on 05/14/24. The Guardian stated the facility called sometime in April and told her they wanted to get a hospice consult. She stated she was surprised, because the facility did not give her the impression that R #1 had declined to the point of needing hospice. The Guardian stated hospice denied R #1, because there was not a reason for her to be on hospice. She stated she received mixed messages from the facility about R #1's weight and food intakes. She stated R #1 ate 80 % of her meals; yet, R #1 still lost weight. The guardian stated R #1 required full assistance with eating her meals, (meaning she required full assistance with eating and drinking and was not able to feed or intake any fluids on her own) (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	O. On 06/18/24 at 9:20 am, during an interview with the Registered Dietician (RD), she stated she reviewed all documentation related to the resident's food and hydration intakes, spoke to staff, and reviewed the resident's weights when she made assessments for residents. The RD reviewed R #1's intake percentages for April and May and stated that she would not think R #1 would continue to lose that much weight. The RD stated, that to her knowledge, the staff assisted the resident with eating in the resident's room. She stated that once a resident declined to the point of not eating, the staff usually considered hospice. P. On 06/17/24 at 9:55 am, during an interview with CNA #8, she stated she assisted R #1 with eating a few time, and she was taught to give R #1 a bite of food and then a sip of water. She stated the food and fluids would come out of the side of the resident's mouth, and sometimes the resident would not swallow her food at all. CNA #8 stated this went on for about one month prior to the resident going out to the hospital. She stated she assisted the resident with eating in her room, not the dining room, and it took around thirty minutes. CNA #8 stated the resident liked to eat in her room. CNA #8 was not aware of the signs of dehydration. Q. On 06/17/24 at 12:45 pm, during an interview with the Tribal Services Director/Guardian, she stated R #1 was admitted to the hospital on Tuesday, 05/14/24, and she was told R #1 was still dehydrated on Friday, 05/17/24. The Guardian stated the resident had a urinary tract infection [UTI; an infection in any part of the urinary system, usually the bladder or urethra (the tube that lets urine leave your body)], kidney stones [when a solid piece of material (renal calculus) develops in the urinary tract], and her electrolytes (keep your nervous system and muscles functioning and your internal environment balanced) were totally off. She stated the hospital was not able to draw any labs on the resident, because she was so dehydrated. She stated the hospital voiced concerns about medical neglect because of the condition R #1 was in when she arrived at the hospital. The Guardian stated she was often given mixed messages about R #1's food intakes and weight loss when she spoke to the facility staff, like one conversation would be that she has gained weight and the next would be that she needed to go on hospice. She stated the resident was totally dependent on staff for all food and fluid intakes. She also stated R #1 was still in the hospital, and now she had a gastrostomy tube (G-tube; a tube surgically inserted through the abdomen into the stomach and used to provide fluids, nourishment, and medications). R. On 06/17/24 at 1:20 pm, during an interview with the Hospital Social Worker (HSW), she stated R #1 was very sick when she showed up to the hospital . The HSW stated R #1 was not eating or drinking, and the doctor decided to place a feeding tube. She stated that was the only way the resident would get nutrition, because she had not been eating or drinking enough. The HSW stated there were also concerns the resident might aspirate. S. On 06/17/24 at 4:02 pm, during an interview with the Hospital Physician, she stated R #1 was admitted to the hospital with high sodium levels, a urinary infection, kidney stones, and sepsis due to an infection. She stated she spoke to someone (unknown person) from the facility,and they told her R #1 had not been eating for approximately six weeks. The Physician stated it was not acceptable for a person, who is not on hospice, to not eat much for around six weeks. She stated the resident was dehydrated and required 13 liters of fluid. She stated this seemed like neglect to her. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	T. On 06/17/24 at 10:14 am, during an interview with the Director of Nursing (DON), she stated they talked to the R #1's Guardian sometime in April, and they suggested Hospice services. The DON stated the facility felt like the resident was declining and was at end of life, due to R #1 not eating and her weight loss. She stated the resident did not receive Hospice services, and she was not sure why. The DON stated that when R #1 did not go on hospice services, the facility wasn't able to do anything else for R #1. The DON stated how do you make someone eat? She stated the resident was on supplements and was assisted with eating. U. On 06/18/24 at 10:22 am, during an interview with Nurse #5, she stated sometimes R #1 ate in the dining room and sometimes in her room. She stated sometimes the CNAs did not get the resident out of bed, and that is why she ate in her room. She stated R #1 stopped eating and was pocketing her food, but she was not sure for how long. The nurse stated the resident also pocketed her medications. V. On 06/18/24 at 1:07 am, during an interview with Speech Therapy (ST), she stated R #1 needed full assistance with eating. She stated the resident did not have issues with fluids, but she did pocket her food when she ate. The ST stated she worked with staff on this and showed them how to use the toothette (soft piece of foam on stick to assist with oral issues) to swipe the food away and to limit the pocketing. ST stated she trained the CNAs on that shift and the information was passed along to the next shift. The ST stated did not conduct a full training with all the staff around this issue. She stated staff needed to take the time with R #1 when she ate. She stated R #1 needed to be in an upright position so the food would not trickle out of her mouth. She stated if staff had the resident in an upright position and utilized the toothette, then R #1 would not have the issue of pocketing her food or trickling out the side of the mouth. The ST stated when she saw staff assisting R #1 with eating the resident was usually in bed.