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	05/10/2024

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

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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 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. 49196 Based on record review, and interview, and observation the facility failed to ensure residents received appropriate treatment and services to prevent decrease in range of motion and mobility to the extent possible, for 1 (R #26) of 4 (R #2, R #26, R #36 and R #13) residents reviewed for range of motion and mobility, when they failed to provide a restorative nursing program [a nursing service with the goal to maximize function and prevent functional decline in residents who require assistance from staff for mobility and activities of daily living (ADLs)] for residents with limited range of motion and/or mobility. This deficient practice could likely result in residents' decreased ability to participate in ADLs and thus failing to reach their highest practicable level of wellbeing. The findings are: 48645 A. Record review of the Journal of the American Medical Directors Association's article titled, Contractures in Nursing Home Residents, dated February 2010, stated Contractures are highly prevalent but preventable in nursing homes. It further stated Contractures will get worse over time without passive range of motion therapy and or a restorative nursing therapy program. B. Record review of R #26's electronic medical record (EMR) revealed the following diagnoses: Contractures (occurs when the muscles, tendons, joints, or other tissues tighten or shorten causing a deformity) of left shoulder, left lower leg, left ankle and foot, left elbow, and right foot and ankle. C. Record review of R #26's care plan, revised on 04/19/24, revealed R #26 was not able to perform ADLs independently and required assistance. R #26's goal was to improve current level of function in bed mobility and muscle Contractures by the review date and to be able to improve range of motion of both upper arms and both legs from 30 to 45 degrees. D. On 05/06/2024 at 10:45 am an during observation of R #26 in her room, the resident lay in bed, in the fetal position (elbows and knees tucked into her chest), and unable to get out of bed. (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 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	E. During an interview on 05/09/24 at 10:34 am, Director of Rehabilitation (DOR) stated R #26 received rehabilitation therapy services in the past, but those services ended on 10/17/2023. The DOR stated R #26 was cooperative with passive range of motion exercises and showed some improvement. The DOR stated R #26 has not received any physical, occupational, or restorative therapy since 10/17/2023. The DOR further stated R #26 would benefit from a restorative nursing program, as this would prevent her contractures from getting worse and could possibly improve.

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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** 48645 35632 Based on record review and interview, the facility failed to prevent an accident and to provide a safe transfer when the facility failed to: 1. Ensure beds were locked. 2. Ensure staff used equipment correctly 3. Ensure staff supervised residents needing help during transfers. 4. Ensure staff used the lift properly and with the appropriate equipment. These failures had the potential to affect 4 (R #5, R #21, #34, and R #58) out of 4 (R #5, R #21, R #34, R #58) residents reviewed for falls. These deficient practices could likely result in the residents falling and injuring themselves. The findings are: Findings for R #21 A. Record review of the face sheet for R #21 revealed the resident was admitted to the facility on [DATE] with multiple diagnoses to include: - Hypotension (low blood pressure), - Anemia (deficiency of healthy red blood cells in blood and they carry oxygen to all parts of the body), - Depression (sadness and loss of interest), - Malnutrition (not taking enough calories). B. Record review of the care plan for R #21, dated 04/18/24, indicated the following: - The resident was at risk for falls due to weakness and deconditioning, opioid use, and cognition. - Ensure to provide a safe environment: Bed locked and tray table with personal items within reach. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	C. Record review of the nursing progress notes for R #21, dated 05/06/24 at 1:04 pm, revealed the resident had a fall on 04/17/24. Staff documented a late entry: The Nursing Assistant (NA) reported to the Nurse that R #21 was found on the floor next to his bed. The Nurse went in the resident's room, and R #21 lay on his right side with his blanket and pillow under him. Medication Technician/Certified Nursing Assistant (CNA) reported that R #21 stated he reached for his water, and the bed moved. The CNA stated the bed was not locked when she checked it. D. On 05/10/24 at 9:33 am, during an interview with Nurse #3, she stated R #21 was on floor when she entered the room. She stated the bed was little higher than normal, and the bed control was on the other side of the bed. Nurse #3 stated the CNA told her the bed was not locked. Nurse #3 stated there was a lever at the foot of the bed that staff can push with their foot to lock the bed and keep it from moving. Nurse #3 stated the CNA told her R #21 said he reached for his water and fell out of bed. She stated there were several reasons staff move the beds in resident rooms, like changing the sheets on the bed and housekeeping will move them to clean. E. On 05/09/24 at 1:18 pm, during an interview with CNA #8, she stated the residents' bed need to be locked at all times. CNA #8 stated they unlock the beds to move them sometimes, but staff should relock the bed when they are finished. She stated if the bed was unlocked when a resident tried to get out of bed or reach for something, then the bed could shift causing the resident to fall. F. On 05/09/24 at 1:46 pm, during an interview with the Administrator, she stated that she would expect to see an investigation into a fall to indicate the bed was unlocked. but she did not see one for R #21's fall from the bed. She expects that any staff who moves the bed for any reason to relock it so it doesn't move. Ensuring staff used equipment correctly G. Record review of the comprehensive Minimum Data Set (MDS; a federally mandated assessment instrument completed by the facility staff) for R #34, dated 04/23/24, revealed R #34 was totally dependent on staff for assistance. R #34 could not use both her upper and lower extremities and required the assistance of two staff and a Hoyer lift for transfers. H. Record review of a progress note in the electronic medical record for R #34, dated 04/22/24, revealed staff documented R #34 fell from the Hoyer lift (medical equipment designed to lift and transfer patients from one place to another) when staff transferred him from his bed to his wheelchair. The record also revealed the Hoyer lift grazed R #34's head when it tipped over. I. Record review of the incident report for R #34's fall, dated 05/02/24, revealed the Director of Nursing (DON) documented certified nursing aide (CNA) #1 and CNA #2 assisted R #34 with a transfer from his bed to his wheelchair using the Hoyer lift on 04/22/24. The report revealed the Hoyer lifts legs were under the resident's wheelchair as the CNAs transferred the resident. The report further revealed CNA #1 pulled hard on R #34 to assist him into his wheelchair, the Hoyer lift tipped over, R #34 landed in his wheelchair hard, and the Hoyer lift grazed the resident's head. An injury was not reported. J. Record review of the facility's in-service training for proper usage of Hoyer lifts, dated 04/26/24, showed CNA #1 and CNA #2 attended the class at the facility on that date. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	K. On 05/06/24 at 12:54 pm, during an interview with R #34, he stated he fell into his wheelchair when the Hoyer lift tipped over on 04/22/24, when staff transferred him from his bed and into his wheelchair. R #34 stated the Hoyer hit his head but did not cause any injury. R #34 stated he did not think the CNAs used the Hoyer lift correctly, because it should never tip over when used right. R #34 further stated while he was in the air, above his wheelchair, in the Hoyer lift, one of the CNAs pulled on him hard, which caused his weight to shift and the Hoyer lift tipped over. L. On 05/07/24 at 11:35 am, during an interview with the DON, she stated the only way a Hoyer can tip over during operation is if staff use it incorrectly. The DON investigated the incident and found that one of the CNAs moved R #34 while he was being lifted in the Hoyer instead of moving the Hoyer. Ensure staff supervised residents needing help during transfers M. Record review of the progress note in the electronic medical record for R #58, dated 05/04/2024, revealed the resident fell on to the floor when staff transferred her from the wheelchair to a shower chair on 05/04/24. N. Record review of the comprehensive MDS for R #58, dated 04/29/24, revealed R #58 required supervision or touching assistance from staff during transfers from wheelchair to shower chair. Staff to provide verbal cues, touching, steadying, and contact guard assistance as the resident transfers from one chair to another. O. Record review of the care plan for R #58, dated 04/26/24, revealed R #58 was at risk for falls related to reduced mobility with the intervention of reminders about safety. P. Record review of the fall investigation for R #58's fall, dated 05/04/24, revealed CNA #3 witnessed R #58 slide out of her wheelchair in the shower room, and R #58 stated I forgot to lock my brakes. The resident had a new bruise to the back of her right forearm and a small scrape on her right elbow. Staff assisted the resident back into her chair, and the resident continued with her shower. Q. On 05/06/24 at 3:05 pm, during an interview with R #58, she stated she slipped out of her wheelchair in the shower room while she transferred herself to the shower chair. R #58 stated she forgot to lock her wheelchair brakes, and that is why she slipped out onto the floor. R #58 did not remember if CNA #3 reminded her to lock her wheelchair brakes or not. R #58 further stated CNA #3 and herself were in the shower room during the incident. R. On 05/9/24 at 11:07 am, during an interview with the DOR (Director of Rehabilitation), he stated that since R #58 required supervision or touching assistance during transfers, CNA #3 should have verbally asked R #58 to lock her wheelchair before transferring or the CNA should have locked the wheelchair. Findings for R #5 S. On 05/06/24 at 8:45 am, during an interview with R #5, she stated recently staff transferred her from the wheelchair to her bed with a Hoyer lift. She said the Hoyer lift tilted, and she fell on the floor. She stated she refused to go to the hospital, because she was not hurt. R #5 stated she thinks the fall had something to do with the sling, but she was not sure. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	T. Record review of the incident report for R #5, dated 03/25/24, revealed staff documented they transferred the resident from the shower chair to her bed using a Hoyer lift. The Hoyer lift tipped to the left, and the resident fell to the floor. The CNAs assisted with the transfer. Resident did not hit her head and refused to go to the hospital. In the witness section it revealed we were transferring resident from the shower chair to the bed using a Hoyer lift, and when we moved residents legs, the Hoyer titled over to the left side. U. On 05/07/24 at 11:35 am, during an interview with the DON, she stated the only way a Hoyer can tip over during operation is if staff use it incorrectly. V. On 05/09/24 at 1:46 pm, during an interview with the Administrator, she stated she would expect to see an investigation into a fall that included a Hoyer lift. She stated staff completed an incident report for the Hoyer lift incident with R #5, but she could not find an investigation of why it happened.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48645 Based on observation and interviews, the facility failed to: 1. Ensure expired supplies were not kept with unexpired supplies. 2. Ensure staff documented the medication refrigerator temperatures. These deficient practices are likely to result in all 11 residents who resided on the 100 hall, as identified on the census list provided by the Executive Director (ED) on [DATE], to have expired supplies that have lost either their potency or effectiveness used on them, or to receive medication that has lost either their potency or effectiveness. The findings are: Ensure expired supplies were not kept with unexpired supplies. A. On [DATE] at 9:25 am, observation of 100 hall medication room revealed a Medstream dressing change kit expired on [DATE]. The expired supplies were stored with other non-expired supplies and not in the area used for the disposal of expired supplies. B. On [DATE] at 9:30 am, during an interview, medication technician (MT) #1 confirmed the supplies were expired. MT #1 stated it was expected the nursing staff to go through the medication storage rooms from time to time and remove any expired or soon to expire supplies. Ensure staff documented temperatures for medication refrigerator. C. Record review of the 100 hall medication room's refrigerator temperature logs revealed staff did not document the temperatures as follows: 1. [DATE] am or pm. 2. [DATE] am or pm. 3. [DATE] am or pm. 4. [DATE] am. D. On [DATE] at 9:25 am, during observation of the 100 hall medication room refrigerator, insulin and other medications that required refrigeration were in the refrigerator. Further observation revealed an analog (dial type) temperature gauge and a digital temperature sensor inside the refrigerator. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	E. On [DATE] at 1:32 pm, during an interview with the Director of Nursing (DON), she stated staff must check all medication storage rooms refrigerator and freezer temperatures once a day and document the temperatures on the temperature log. She stated staff checked to make sure the refrigerators maintained a temperature range of 36 to 46 degrees Fahrenheit, which preserved temperature controlled medications.