

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  325078	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  08/01/2024
NAME OF PROVIDER OR SUPPLIER  Retirement Ranches Inc.		STREET ADDRESS, CITY, STATE, ZIP CODE  2221 Dillon Clovis, NM 88101	

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 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>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.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 15879</b></p> <p>Based on observations, record reviews, interviews, and facility policy review revealed the facility failed to ensure one out of six medication carts and one out of two treatments carts were securely locked when unattended. This failure put the residents at risk of taking medications that were not theirs.</p> <p>Findings include:</p> <p>Review of the facility's policy titled, Security of Medication Cart with a revised date of April 2007, revealed the medication cart shall be secured during medication passes. Review of the Policy Interpretation and Implementation revealed the nurse must secure the medication cart during medication pass to prevent unauthorized entry .the medication cart should be parked in the doorway of the resident's room during the medication pass .the cart doors and drawers should be facing the resident's room .medications carts must be securely locked at all times when out of the nurses' view .when the medication cart is not being used, it must be locked and parked at the nurses' station.</p> <p>During an observation on 07/29/24 at 10:54 AM, one medication treatment cart on the 300 hall was left unlocked while Registered Nurse (RN) 1 went into a room on the 300-hall with the door was closed. Observation further revealed RN1 did not have the cart in her view.</p> <p>During an observation on 07/29/24 at 10:57 AM, RN1 went back to the medication cart on the 300-hall, and she did not lock it.</p> <p>During an observation on 07/29/24 at 11:33 AM, both the medication cart and the treatment cart were sitting side by side, unlocked and unattended by the nurses, adjacent to the electrical room on the 300-hall. Observation further revealed one staff walked by the carts. Observation revealed this surveyor was able to open the drawers and medications were inside.</p> <p>During an observation on 07/29/24 at 11:35 AM, RN1 walked to the medication cart and picked up something from it, left the cart unlocked, went into room [ROOM NUMBER] with the door closed, and the medication cart was not in her view. Observation further revealed a Certified Nursing Assistant (CNA) walked by the unlocked cart.</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 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an observation on 07/29/24 at 11:35 AM, the treatment cart on the 300-hall was unlocked and the nurse was not in view of the cart.</p> <p>During an observation on 07/29/24 at 11:37 AM, RN1 went to the medication cart located on the 300-hall, prepared the medication, went into room [ROOM NUMBER], closed the door, and left the medication cart unlocked. Observation further revealed the medication cart was not in view of RN1.</p> <p>During an observation on 07/29/24 at 11:41 AM, RN1 went back to the medication cart on the 300-hall, retrieved something, and went back into room [ROOM NUMBER], closed the door and the medication cart was not in her view. Observation further revealed two CNAs walked by the medication cart.</p> <p>During an observation on 07/29/24 at 11:43 AM, RN1 walked back to the medication cart located on the 300-hall, prepared medications, left the medication cart unlocked and went into room [ROOM NUMBER]. Observation further revealed RN1 could not see her medication cart. Observation at 11:46 AM revealed RN1 went back to the medication cart, left it unlocked, and went back into room [ROOM NUMBER] which was out of her view.</p> <p>During an observation on 07/29/24 at 12:45 PM and 1:45 PM, the treatment cart located in the hallway by the nurse's station on the 200-hall by room [ROOM NUMBER] was unlocked and unattended.</p> <p>During an observation on 7/29/24 at 3:50 PM, RN1 went into room [ROOM NUMBER] to do an accucheck and left the medication cart on the 100-hall unlocked and not in her view.</p> <p>During an observation on 07/29/24 at 4:26 PM, the medication cart in the common area of the 100-hall was not locked and was not in view of the nurse.</p> <p>During an observation on 07/30/24 at 2:54 PM, the medication cart was unlocked on the 200-hall and RN1 was not in view of the medication cart. Observation further revealed one CNA walked by the cart. During the observation, RN1 came back to the medication cart, took something from it, and did not lock the medication cart. Observation further revealed RN1 walked down to the 300-pod completely out of view of the unlocked medication cart. Observation revealed there were medications in the drawer when opened.</p> <p>During an observation on 07/30/24 at 2:59 PM, RN1 revealed there were prescription medications and over the counter medications in the medication cart, and the cart was unlocked.</p> <p>During an interview on 07/30/24 at 2:59 PM, RN1 revealed she had not locked the medication cart because she was in and out of the resident's room. She further revealed the narcotic box located in the medication cart was secured with a lock even though the medication cart itself was unlocked. Interview with RN1 further revealed she had stayed within the vicinity of the medication cart and did not have to lock it if the medication cart was in view. Interview further revealed, when RN1 was asked if she considered in the vicinity when she walked from the 200- pod down the hall to the 300-pod and left the medication cart unlocked. RN1 revealed she was not in the vicinity and the medication cart should have been locked. Interview with RN1 revealed the medication cart was supposed to be locked when out of view so no one else could have access to the medications. During the interview RN1 stated a resident could get into the medication.</p> <p>(continued on next page)</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 07/30/24 at 4:16 PM, the Director of Nursing (DON) stated anytime the nurse was not in front of the medication and treatment carts the carts should be locked. The DON further stated you never knew who was around the corner that could get into the carts, which have medications and creams located in them. The DON stated a lot of the facility's residents had dementia and would not know to not take the medications or creams and could eat them. The DON stated the narcotics needed to be behind two locks and if the outside lock was not locked then the narcotics were only under one lock.</p>		

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<p>F 0803</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 03115</p> <p>Based on observations, menu review, interview, and facility policy review, the facility failed to ensure menus were in place for all physician prescribed diets and failed to follow the menu for 80 of 80 census residents. This failure has the potential for residents to get the incorrect food in accordance with their diets; not receive nutritionally adequate meals; and receive repetitive food items.</p> <p>Findings include:</p> <p>Review of the facility's policy titled, Menus with a revised date of October 2017, revealed menus for regular and therapeutic diets are written at least two (2) weeks in advance and are dated and posted in the kitchen at least one (1) week in advance. The dietitian reviews and approves all menus. Copies of menus (as served including substitutions) are kept on file for at least 5 weeks.</p> <p>The menu titled Main Meal Week 3 listed the breakfast, lunch, and dinner for Monday 07/28/24 through Saturday 08/03/24. The menu for the noon meal stated Picadillo, refried beans, flour tortilla, lettuce and tomato, sour cream, and creme [NAME] were supposed to be served. The menu did not include any portion sizes and did not specify a diet.</p> <p>On 07/31/24 at 11:01 AM, a menu for the resident diets and with portion sizes was requested. The Director of Dietary (DOD) stated that was the only menu he had, and he did not have menus listing the portion sizes or menus for the therapeutic or texture modified diets ordered by the physicians. He stated they just followed the menu provided, and the cook pureed or chopped the items on the menu. He stated if they could not be pureed, the cook decided what to serve them and decided on the portion sizes.</p> <p>During observations of the meal on 07/31/24 from 11:30 AM to 12:00 PM, the DOD and Cook1 served the noon meal from the steam table. They served the residents on regular diets a six-ounce scoop of Picadillo, one flour tortilla, six-ounce scoop of lettuce and tomato, sour cream, and a bowl of creme [NAME]. They served the residents on mechanical soft diets six ounces mechanical soft Picadillo, chopped up tortilla, six ounces chopped lettuce, and a cup of creme [NAME]; and the residents on puree diets received six-ounces of mashed potatoes, four-ounces of picadillo, gravy on the potatoes and picadillo and a bowl of tomato soup. The residents with orders for or a care plan intervention of finger foods received chicken fingers, fried zucchini strips, and tater tots. No refried beans were available on the steam table as listed on the menu for 07/31/24.</p> <p>During an interview on 07/31/24 at 12:00 PM, the Director of Dietary verified they did not serve the refried beans or equal alternate. He stated the refried beans were not available in the facility. He also verified the menu did not include any portion sizes and stated he did not have any planned menus for therapeutic or mechanically altered diets. He stated he had [AGE] years experience in the restaurant industry, and the cook had [AGE] years experience as a cook in a nursing home. He stated he felt they could make the decision on what to serve the residents on mechanically altered and therapeutic diets.</p> <p>(continued on next page)</p>		

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<p>F 0803</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>During an interview on 07/31/24 at 12:48 PM, the Director of Nursing (DON) stated they should have followed the menu. The DON stated if they did not have refried beans then they could have run down to the store to buy some.</p> <p>During an interview on 07/31/24 at 1:10 PM, the Registered Dietitian (RD) stated she had only been the RD at the facility for a month. She stated the previous dietitian told her the DOD should have had a binder containing the spreadsheets/menus with portion sizes listed for the regular, therapeutic, and the texture modified diets. She stated she expected them to follow the individual diets/ menus listed on the menus/spread sheets. She stated the spread sheets would list the portion sizes and the food items planned on each of the diets.</p> <p>During an interview on 07/31/24 at 3:28 PM, the DOD stated he did not have any binders with menus and spread sheets.</p> <p>On 08/01/24 at 8:54 AM, the five-week cycle of menus were requested from the DOD and was not provided.</p> <p>During confidential resident interviews conducted on 07/29/24 and 07/30/24, three residents stated the menus were not consistently followed.</p> <p>Review of resident council meeting minutes, dated 04/29/24, revealed one resident stated the menus were not followed, and she had a hard time getting an alternate.</p> <p>During an interview on 07/29/24 at 11:56 AM, Certified Nurse Aid (CNA) 2 stated R34 and R42 were supposed to receive finger food. She stated most of the time they get fried chicken fingers and French fries.</p> <p>Observations revealed R34 and R42 received chicken fingers and fries on 07/29/24 and chicken fingers and tater tots on 07/31/24.</p> <p>On 07/31/24 at 1:20 PM the DON provided a document titled Order Report by Category: 07/01/24 - 07/31/24. She stated it contained the residents' diets as ordered by the physician. Review of the document revealed the facility had residents on the following diets: regular, regular with fortified foods, no added salt with fortified foods, low concentrated sweets, low concentrated sweets no added salt with fortified foods, puree texture diet, puree with fortified foods, mechanical soft with fortified foods, no added salt mechanically soft, cardiac regular diet with fortified foods, finger foods only with fortified foods, and regular gluten free foods with no [NAME] products.</p> <p>A review of the menu revealed there was no planned menu for these diets and the menu for the week only listed the food items and did not include portion sizes.</p>