STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	325085	A. Building B. Wing	01/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
San Juan Care Center	806 West Maple Street Farmington, NM 87401

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35632 Based on record review and interview, the facility failed to notify the Power of Attorney (POA; legal authorization for a designated person to make decisions about another person's property, finances, or medical care) when R #1's oxygen saturation (the amount of oxygen in the blood) was low and required supplemental oxygen (oxygen therapy; a therapy treatment which provides extra oxygen) through a nasal cannula (a small, flexible tube that delivers oxygen to the nose through soft prongs) for 1 (R #1) of 3 (R #1, #2, and #3) residents reviewed for change in condition. If the facility is not notifying the POA when there is a change in condition then the POA is unable to make decisions related to treatment and advocate for the resident's care. The findings are: A. Record review of the face sheet revealed that R #1 was admitted to the facility on [DATE] and was discharged on [DATE]. R #1 had the following diagnoses: - Surgical amputation below knee (surgical removal of part of the leg), - Sepsis (blood stream infection), - Type II diabetes (body is resistant to insulin and causes high blood sugar levels), - Cellulitis (serious bacterial infection of the skin) of a limb. - This is not an all inclusive list. B. Record review of R #1's change in condition evaluation note, dated 12/10/24 at 1:33 am, indicated R #1 had normal vitals with increased confusion and disorientation. The resident fell out of bed, was assessed, and did not have an injury. R #1 had shortness of breath and a cough. Staff called the on-call physician, and R #1 to receive a chest x-ray later in the day. The note did not indicate staff notified the family member (FM). C. Record review of R #1's change in condition evaluation note, dated 12/10/24 at 5:15 am, indicated the following: - R #1 had an oxygen saturation of 66 percent (%; normal saturation is between 90% and 100%). All other vitals were within normal range. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- The Mental Status Evaluation Section indicated R #1 had increased confusion and disorientation. Interventions included placing R #1 on supplemental oxygen and a chest x-ray later in the day. - The Comment Section indicated resident was put on supplemental oxygen during the night and a chest x-ray was ordered. The primary nurse received report, checked on the resident, and found him with his legs hanging off the bed. The resident's nasal cannula was off. Staff took the resident's vitals, and the resident had 47% oxygen saturation on room air. Staff applied the resident's nasal cannula, and his oxygen saturation increased to 6 liters per minute (lpm). The resident's oxygen saturation came up to 66%. Resident tried to verbalize and answer questions, but he did not make sense. Emergency Medical Services (EMS) was dispatched, and the resident left with EMS for the hospital around 6:00 am. - The note did not indicate staff notified the family member. D. On 01/08/24 at 12:17 pm during an interview with R #1's FM/POA, she stated R #1 called her the night of 12/09/24, and he was calling out for help. She stated R #1 did not seem normal to her so she hung up and called the nursing station. The POA stated she asked if someone would go and check on R #1. She stated she called back twice after that and never spoke to anyone. She stated the facility did not call her about R #1's change in condition that occurred in the early morning on 12/10/24. E. On 01/09/25 at 8:30 am, during an interview with the Assistant Director of Nursing (ADON), she stated she came in at 5:00 am on 12/10/24, and the night shift nurse told her that R #1 was placed on oxygen for low saturation levels. The ADON stated she went to check on R #1, found him without his oxygen on, and he was confused. She stated she placed the oxygen on the resident, turned the oxygen up to 6 lpm, and his saturations came up to 66%. The ADON stated that was when R #1 was sent out to the hospital. She stated she called and left a message for R #1's FM/POA when he was sent to the hospital on 12/10/24 at 6:00 am. She stated she did not notify the FM/POA prior to the resident's change in condition when he started using oxygen on 12/09/24, because she was not working on 12/09/24. The ADON stated that she did not see any documentation in the resident's medical record that staff notified the FM/POA of the resident's change in condition on 12/10/24 at 1:33 am, and the night nurse did not tell her that they notified the FM/POA when the resident was placed on oxygen for low saturations. F. On 01/09/25 at 8:40 am, during an interview with Director of Nursing (DON), she stated if a resident had a change in condition then staff should notify the resident's family/POA at that time.