

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 325085	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/13/2025
NAME OF PROVIDER OR SUPPLIER San Juan Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0627</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to meet regulatory requirements when discharging 1 (R #68) of 1 (R #68) resident when staff failed to ensure proper notification was given to the resident, conduct discharge planning, and confirm of resident receipt of the discharge notice. These failures had the potential for an incomplete and unsafe discharge and increase risk of resident harm.</p> <p>The findings are:</p> <p>A. Record review of the facility's Transfer and Discharge policy, dated 10/24/22, revealed the facility must permit each resident to remain in the facility, including when a resident endangered the health or safety of others, and should not discharge the resident unless one of six regulatory criteria were met. The policy directed staff to ensure documentation was complete, involve the physician in the decision, notify the residents and/or their representative, issue a written notice, and assist with safe and appropriate discharge planning. The policy also stated residents must be informed of their right to appeal, and staff must notify the Ombudsman.</p> <p>B. Record review of R #68's face sheet revealed he was admitted to the facility on [DATE] with the following diagnoses:</p> <ul style="list-style-type: none"> - Schizoaffective disorder (a mental condition that causes both psychosis and mood problems), - Generalized anxiety disorder, - Opioid dependence (physical dependence on opioids), - Diabetes mellitus (DM; metabolic disease). <p>C. Record review of R #68's progress notes revealed the following:</p> <ul style="list-style-type: none"> - Dated 05/07/25, the resident was discharged on 05/07/25, after he threw coffee on the Assistant Director of Nursing (ADON). - Dated 05/06/25, the facility Medical Director documented the resident was no longer safe to remain in the facility due to escalating verbal and physical behaviors. - Dated 05/06/25, the Administrator documented R #68 was in jail and presumably discharged . <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 0627</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>D. On 06/12/25 at 2:25 P.M., during an interview, the Director of Nursing (DON) stated the resident was arrested on 05/06/25 for throwing coffee on the ADON, and the Administrator hand-delivered the discharge paperwork to the jail. She stated a second notice was provided to the resident on 05/07/25 when he returned to the facility. She stated the resident's physician, the facility's Medical Director, was notified of the discharge. She stated R #68 was his own responsible party. She stated the resident did not receive his medications when they discharged him, and they did not create a discharge plan with R #68. She stated it was her expectation the resident would receive a complete and appropriate discharge.</p> <p>E. On 06/12/25 at 2:45 P.M., during an interview, the Administrator stated the facility issued a formal discharge notice to R #68 on 05/06/25, and he personally delivered it to the jail. He stated the notice was handed to the receptionist for delivery, and he could not confirm whether the resident received it. He stated the resident returned to the facility on [DATE], and the resident stated he did not receive any paperwork while in jail. He stated he gave R #68 a copy of his discharge papers, and he verbally encouraged the resident to go to the hospital. The Administrator stated he documented the information in the administrative notes in R #68's progress notes. The Administrator stated the facility denied the resident reentry to the facility due to safety concerns. The Administrator stated the team felt comfortable with the decision based on the resident's unsafe behavior.</p> <p>F. On 06/12/25 at 3:00 P.M., during an interview, the Regional Nurse Consultant (RNC) stated proper discharge planning did not occur for R #68. She stated it was her expectation staff would have developed a discharge plan for R #68.</p>		