STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	325086	A. Building B. Wing	09/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Casa Maria Healthcare	1601 South Main Street Roswell, NM 88203

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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	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** 50207 Based on record review and interviews, the facility failed to prevent an accident for 1 (R #1) of 3 (R #1, R #2, and R #3) residents reviewed for falls when: 1. R #1 sustained (14) falls in a 6.5 month period. 2. The facility did not implement adequate interventions to prevent falls 3. Neurochecks for unwitnessed falls and falls in which the resident hit her head were incomplete per policy. 4. One- to-one staffing was assigned to R #1, however staff were assigned other duties and R #1 had 3 falls during the time she was ordered to have one-to-one staffing in which she sustained injury to her head. These deficient practices likely resulted in R #1 sustaining multiple acute subarachnoid hemorrhage (bleeding between the space between the brain and tissue covering the brain) and passing away (6) days after her last fall at the facility. The findings are: A. Record review of R #1's face sheet revealed R #1 was admitted to the facility on [DATE] with multiple diagnoses including: - Unspecified dementia without behavioral disturbance, - Psychotic disturbance, - Mood disturbance, - Anxiety, - Unspecified fracture of right ilium (the large broad bone forming the upper part of each half of the pelvis), subsequent encounter for fracture with routine healing. - Urinary tract infection, site not specified. (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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	- Essential hypertension (high blood pressure.) - Other reduced mobility. - Need for assistance with personal care. - Specified sequelae of cerebral infarction (symptoms that occur after a stroke.) - Unspecified dementia, unspecified severity. - Age-related osteoporosis with current pathological fracture, right pelvis. - Repeated falls. B. Record review of R #1's quarterly Minimum Data Set (MDS; a federally mandated assessment instrument completed by facility staff), dated [DATE], revealed the following: 1. A Brief Interview for Mental Status (BIMS; a screening for cognitive impairment) score of 04, severe impairment, 2. Wandered daily, 3. Utilized a wheelchair for mobility, 4. Required substantial to maximal assistance when walking up to 50 feet, 5. Functional limitation in range of motion on one side of lower extremities (legs), 6. Had shortness of breath when lying flat, 7. Had two or more falls without injury since admission, reentry, or prior assessment, 8. Took an anticoagulant and indication was noted, 9. Did not receive any physical, occupational, or restorative therapy. 10. Signed by the Registered Nurse (RN)/MDS and the Social Worker. 11. Assessment marked completed on [DATE]. C. Record review of R #1's Physician Orders revealed an order for Eliquis (blood thinner to prevent/treat blood clots) 2.5 milligram tablet to be given twice daily and started on [DATE]. D. Record review of R #1's Care Plan, dated [DATE], revealed R #1 was a high risk for falls and included the following interventions: 1. Dated [DATE], review information on past falls and attempt to determine cause of falls. Record possible root causes. Alter remove any potential causes if possible. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	2. Dated [DATE], Physical Therapy (PT) to evaluate and treat as ordered or as needed (PRN). 3. Dated [DATE], intervention related to fall risk included R #1 had frequent urinary track infections (UTI) which resulted in behavior changes. Consider UTI with each fall and get a urology consult as soon as possible. 4. The care plan did not address the resident's use of Eliquis or the risk associated with use. E. Record review of the facility's Neurological Assessments policy, dated ,d+[DATE], revealed nursing staff to perform neurological assessments as follows: 1. Upon Attending Physician order. 2. Following an unwitnessed fall. 3. Following a fall or other accident/injury involving head trauma. 4. When indicated by resident's condition. 5. To be completed every 30 minutes four times (a check to be completed every 30 minutes for two hours), then every hour four times (a check to be completed every hour for four hours), then every four hours four times (a check to be completed every four hours for 16 hours), and then every shift for a combined total of 72 hours. F. Record review of R #1's Fall with Injury report, R #1's Electronic Health Record (EHR), R #1's progress notes and R #1's neurocheck evaluation revealed the following: 1. Progress noted dated [DATE], R #1 was on the floor behind door. Resident noted to have blood on face, gown, and floor, large bump and abrasion noted to forehead, bump and bruising noted to right forearm. Resident unable to give description of fall. For fall dated [DATE], the facility did not complete 15 out of sixteen required neurochecks (a brief neurological assessment performed by staff repeatedly to monitor a resident's neurological status). 2. Progress note dated [DATE], an unknown Certified Nursing Assistant (CNA) notified the nurse that R #1 was on the floor. For fall dated [DATE], the facility did not complete four out of sixteen required neurochecks. Care Plan revised [DATE], intervention related to fall risk included anticipate and meet the resident needs and be sure R #1's call light is within reach and encourage R #1 to use it for assistance as needed. R #1 needs prompt response to all requests for assistance. 3. Progress Note dated [DATE], the nurse heard a loud bang and saw the CNA at back door on 100 hall. Resident lay supine on the floor. Dated [DATE], a hospital emergency room After Visit Summary - the reason for the visit was a fall. Diagnoses listed were unspecified fall and closed head injury. The EHR did not contain a Fall with Injury report for [DATE]. For fall dated [DATE], the facility did not complete 12 out of sixteen required neurochecks. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	I. Record review of the R #1's EHR dated [DATE] and [DATE], handwritten notes which described what R #1 did throughout the day while one-to-one staffing was provided. The EHR did not contain additional documentation for other dates of one-on-one staffing, such as notes which described what R #1 did throughout the day while the one-to-one staffing would have been provided. J. Record review of R #1's EHR, R #1's progress notes and R #1's neurocheck evaluation revealed the following: 1. Fall with Injury report dated [DATE], revealed staff saw resident lying on her back holding on to her head. Staff assessed resident. Resident had a quarter size hematoma to back of head. No other injuries noted. Progress notes dated [DATE], R #1 lay on the ground, on her back, and held her head. For fall dated [DATE], the facility did not complete seven out of sixteen required neurochecks. 2. Progress note dated [DATE] at 12:52 am, Change of Condition: R #1 hit her head which caused a subarachnoid hemorrhage (bleeding in the space between the brain and the tissue covering the brain) during an unwitnessed fall. Fall with Injury report dated [DATE], revealed an aide found the resident on floor in bedroom. The resident walked from restroom back to bed and fell to floor. Resident sustained large hematoma to left side of head which caused pain to patient. Resident had skin tear to left elbow and bruise to the left hip and right inner knee. Emergency Services was called, and resident was transported to the hospital. Progress noted dated [DATE] at 7:37 am revealed spoke with daughter after return from ER, per daughter all scans and labs were normal. For fall dated [DATE] at 12:52 am, the facility did not complete 15 out of sixteen required neurochecks. K. Record review of R #1's hospital emergency room (ER) Physician's Documentation, dated [DATE], revealed .This patient has been recently seen in this Emergency Department today. The patient has been recently seen in this Emergency Department, this week, last week, a couple of weeks ago, last month, for similar complaints. Patient returns to the ED [Emergency Department] via EMS [Emergency Medical Services]. She resides at a local ECF [Extended Care Facility]. She has had increasing frequency of falls. She was here earlier in the evening for a fall. Imaging studies were without traumatic abnormality. She was returned to the ECF. Once there, she fell again. Staff state that she was found on the floor. Now she has AMS [Altered Mental Status], staring off to the right. She is not speaking to me, she is agitated. HPI [History of Present Illness] obtained from daughter. L. Record review of R #1's hospital discharge documentation, dated [DATE], revealed the following. 1. Computed tomography (CT scan; a noninvasive diagnostic imaging procedure that uses a computer to take data from several X-ray images of structures inside a human and converts them into pictures on a monitor) head without contrast showed multiple acute subarachnoid hemorrhage in the pontine, parietal, and frontal parietal areas (areas of the brain). 2. Multiple acute subarachnoid hemorrhage secondary to anticoagulation with Eliquis, status post multiple mechanical falls. M. Record review of R #1's Nursing Note, dated [DATE], revealed R #1 returned to the facility from hospital, status post (status after an intervention) subarachnoid hemorrhage from fall. N. Record review of R #1's Clinical Physician Order, dated [DATE], revealed an order for hospice with a diagnosis of subarachnoid hemorrhage. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	O. Record review of R #1's Minimum Data Set, dated dated dated [DATE] identified that R #1 was deceased . P. On [DATE] at 9:25 am and [DATE] at 9:11 am, during an interview with R #1's daughter, she stated her mother passed away on [DATE] due to injuries she sustained from a fall at the facility, which never should have happened. She stated her mother fell a total of 11 times from [DATE] to [DATE]. She stated her concern was, each time her mother fell , the facility did not do anything to mitigate the falling or to prevent it from happening. She stated four or five of her mother's falls resulted in trips to the emergency room . R #1's daughter stated she had to ask for a care plan meeting, because the facility did not schedule one to put interventions in place. She explained that during the last meeting on [DATE], it was agreed that her mother would have one-to-one staffing. She stated the one-to-one only lasted two days. R #1's daughter stated if the facility would have done their part, then her mother probably would not have had the fall that cost her life. R #1's daughter also stated her mother was not able to use a call light appropriately due to the decline in her mental abilities. She stated her mother did not know what it was for or when to push the button. Q. On [DATE] at 10:04 am, during an interview with the Director of Nursing (DON), she stated R #1's team met and placed R #1 on a one-on-one staffing intervention on [DATE]. The DON stated she would not expect for a resident to continue to have falls if one-to-one staffing was provided. The DON stated the staff that provided one-on-one staffing should have documented what occurred while the one-on-one staffing was provided, but she was not able to provide additional documentation that one-on-one staffing was scheduled beyond [DATE] and [DATE]. R. On [DATE] at 8:42 am, during an interview with CNA #1, she stated she was the one-on-one staff assigned to R #1 during her second fall on [DATE]. CNA #1 stated she was assigned other duties, such as answering call lights and passing out drinks to other residents, while assigned as R #1's one-on-one staff. S. On [DATE] at 8:51 am, during an interview with CNA #2, she stated that she was assigned to work two shifts as R #1's one-on-one staff, but she could not remember the dates. CNA #2 stated on the first day she was assigned as R #1's one-on-one staff, R #1 fell and went to the hospital before she arrived at work. CNA #2 stated she remembered walking into work on the second day she was assigned to be R #1's one-on-one staff and saw the bruises to R #1's face and arms. CNA #2 stated she was assigned to answer call lights for other residents while assigned as R #1's one-on-one staff. Based on record review and interviews, Immediate Jeopardy was identified in person to the Administrator on [DATE] at 10:35 am. The facility took corrective action by providing an acceptable Plan of Removal (POR) on [DATE] at 11:06 am. The facility's implementation of the POR was verified onsite on [DATE] at 12:00 pm with completion of the following: 1. A re-evaluation of all residents fall risks and care plans. 2. An audit of previous falls in the past 30 days to ensure new interventions were put in place and neurological checks were completed. 3. Reeducation of staff regarding one-on-one staffing expectations and completing neurological checks. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	After removal of the Immediate Jeopardy, the deficiency remained at a G scope and severity for a pattern of harm.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	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. 50207 Based on observation and interviews, the facility failed to ensure all treatment carts were locked while unattended. This deficient practice had the potential to affect all 94 people residing in the facility by allowing unauthorized persons access to their medical supplies and personal health information. The findings are: A. On 08/23/24 at 8:23 am, during a random observation of the facility, the treatment cart located in the short hallway between the dining room and the nurse's station was unlocked, and facility employees were not in the area. B. On 08/23/24 at 8:24 am, during an interview with Certified Nursing Assistant (CNA) #1, she confirmed the treatment cart was unlocked, and facility employees were not in the area. C. On 08/23/24 at 8:26 am, during an interview with Assistant Director of Nursing (ADON) she stated the treatment cart should be locked and secured while not in use.