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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 325086 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 09/20/2024 |
| NAME OF PROVIDER OR SUPPLIER Casa Maria Healthcare | | STREET ADDRESS, CITY, STATE, ZIP CODE 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.

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| <p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>50207</p> <p>Based on observation and interview, the facility failed to promote care with dignity and respect for 4 (R #3, R #44, R #56, and R #70) of 6 (R #3, R #12, R #44, R #56, R #64, and R #70) residents reviewed during a random dining observation when the facility failed to serve lunch at the same time to all the residents who sat at the same dining table. This deficient practice could likely result in residents feeling frustrated and disappointed.</p> <p>The findings are:</p> <p>A. On 09/16/24 at 12:04 pm, during a lunch observation in the dining room, revealed the following:</p> <ol style="list-style-type: none"> 1. R #12 and R #56 sat at the same table waiting for lunch to be served: <ol style="list-style-type: none"> a. R #12 was served his meal at 12:22 pm and R #56 watched R #12 eat his meal. b. R #56 was served his meal at 12:29 pm. 2. R #3, R #44, R #64, and R #70 sat at the same table waiting for lunch to be served: <ol style="list-style-type: none"> a. R #64 was served his meal at 12:34 pm and R #3, R #44, and R #70 watched R #64 eat his meal. b. R #3 was served her meal at 12:36 pm and R #44 and R #70 watched R #3 eat her meal. c. R #70 was served his meal at 12:40 pm and R #44 watched R #70 eat his meal. d. R #44 was served her meal at 12:46 pm. <p>B. On 09/16/24 at 12:26 pm, during an interview with R #12, he stated that he would prefer to have his meal served at the same time his friend's meal is served so they can eat together.</p> <p>C. On 09/16/24 at 12:37 pm, during an interview with R #3, R #44, R #64, and R #70, they all agreed that they prefer to have their meals served at the same time as those sitting at the same table.</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 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>D. On 09/18/24 at 11:12 am, during an interview with the Dietary Manager (DM), he confirmed that residents having to wait from seven to twelve minutes to be served is too long. He stated his expectation is to have residents seated at the same table to be served at the same time or within a few minutes of each other.</p> | | |

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| <p>F 0553</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>Allow resident to participate in the development and implementation of his or her person-centered plan of care.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49827</p> <p>Based on record reviews and interviews, the facility failed to ensure the resident's right to participate in the care planning process for 3 (R #24, R #30, and R #96) of 5 (R #24, R #30, R #90, R #96, and R #294) residents reviewed for care plans. If the facility fails to ensure resident's participation in the care planning process, then residents are likely to feel unimportant and uninformed. The findings are:</p> <p>R #24</p> <p>A. Record review of R #24's Admission Record revealed R #24 was admitted to the facility on [DATE] with multiple diagnosis including:</p> <ol style="list-style-type: none"> 1. Unspecified Sequelae of Unspecified Cerebrovascular Disease (conditions that impact blood vessels in the brain). 2. Bipolar Disorder (a disorder associated with episodes of mood swings ranging from depressive lows to manic highs). 3. Anxiety Disorder. 4. Anoxic Brain Damage (damage to the brain from lack of oxygen), not elsewhere classified. 6. Difficulty in walking <p>B. Record review of R #24's Admission Minimum Data Set Assessment (MDS; a federally mandated assessment instrument completed by facility staff), dated 06/30/24, revealed a Brief Interview of Mental Status (BIMS; a screening for cognitive impairment. Scores range from 00 to 15, with 15 - 13 is cognitively intact, 12 - 8 is moderately impaired, 7 - 00 is severe impairment) score of 15.</p> <p>C. On 09/17/24 at 8:45 am, during an interview with R #24, she stated that she does not have a Power of Attorney (POA; legal authorization for a designated person to make decisions about another person's property, finances, or medical care) in place, and she has not had a care plan meeting since being admitted to the facility.</p> <p>D. Record review of R #24's Electronic Health Record revealed the record did not contain any evidence of a care plan meeting.</p> <p>E. On 09/19/24 at 10:16 am, during an interview with the Regional Social Services Consultant (RSSC), he confirmed there has not been a care plan meeting for R #24 since she was admitted to the facility and stated, she should have had a care plan meeting already.</p> <p>R #30</p> <p>(continued on next page)</p> | | |

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| <p>F 0553</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>F. Record review of R #30's Admission Record revealed R #30 was admitted to the facility on [DATE] and readmitted to the facility on [DATE] with multiple diagnoses including:</p> <ol style="list-style-type: none"> 1. Acute and Chronic Respiratory Failure with Hypercapnia (a condition that requires long-term regular care that can become an emergency with too much carbon dioxide in the blood). 2. Muscle weakness, generalized. 3. Difficulty in walking. 4. Polyneuropathy, unspecified (a condition where a person's nerves located outside of the brain and spinal cord are damaged). 5. Hypertensive Heart Disease with heart failure. <p>G. On 09/16/24 at 2:12 pm, during an interview with R #30, he stated that he is not invited to attend his care plan meetings, and he does not have a POA in place.</p> <p>H. On 09/16/24 at 10:16 am, during an interview with the RSSC, he stated the facility had a care plan meeting for R #30 on 07/18/24, but the resident was in the hospital. He confirmed the meeting should not have occurred stating it defeats the purpose to have a care plan meeting while the resident is not present.</p> <p>R #96</p> <p>I. Record review of R #96's Admission Record revealed R #96 was admitted to the facility on [DATE] with multiple diagnosis including:</p> <ol style="list-style-type: none"> 1. Malignant Neoplasm of Colon, unspecified (Colon Cancer). 2. Type 2 Diabetes, Mellitus without complications. 3. Acute Respiratory Failure with Hypoxia. 4. Difficulty in walking. 5. Encounter for surgical aftercare following surgery on the digestive system. <p>J. Record review of R #96's Minimum Data Set Assessment, dated 08/27/24, revealed a BIMS score of 13.</p> <p>K. On 09/17/24 at 10:21 am, during an interview with R #96, she stated that she couldn't remember having a care plan meeting since being admitted to the facility. She stated that she would like to attend her care plan meetings because it's important for her to know everything she can about her care.</p> <p>L. Record review of R #96's NM Care Plan Conference (the facility's form to document care plan meetings), dated 07/18/24, revealed her POA attended but R #96 Did not want to attend.</p> <p>(continued on next page)</p> | | |

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| <p>F 0553</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>M. Record review of R #96's NM Care Plan Conference, dated 08/01/24, revealed R #96's POA attended the meeting, but R #96 Allows POA/daughter [R #96's daughter's name] to handle her affairs.</p> <p>N. Record review of R #96's NM Care Plan Conference, dated 08/21/24, revealed that R #96's POA attended the meeting, but R #96 Has a POA, low BIMS.</p> <p>O. On 09/18/24 at 10:56 am, during a follow-up interview with R #96, she stated the following:</p> <ol style="list-style-type: none"> 1. She has never told the facility that she did not want to attend her meetings. 2. She has not been invited to attend a care plan meeting since being admitted to the facility. 3. She did sign POA to her daughter, but it's still important for her to participate in her care planning process. <p>P. On 09/19/24 at 10:09 am, during an interview with the RSSC, he stated his expectation is for all residents, regardless of their BIMS score to be invited to participate in every step of the care planning process including attending care plan meetings.</p> <p>50207</p> | | |

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| <p>F 0561</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34439</p> <p>Based on record review, observations, and interviews, the facility failed to promote residents' choices for 2 (R #28 and R#96) of 2 (R #28 and #96) residents reviewed for choices when staff failed to:</p> <ol style="list-style-type: none"> 1. Announce themselves prior to entering R #28's room. 2. Accommodate R #96's choice to have her oxygen tube attached to the rail of her bed. <p>These deficient practices are likely to result in the resident's needs, choices and preferences not being honored. The findings are:</p> <p>R #28</p> <p>A. Record review of R #28's current physician orders, R #28 was admitted to the facility on [DATE] with multiple diagnosis including:</p> <ol style="list-style-type: none"> 1. Acute and Chronic Respiratory Failure. 2. Other reduced mobility. 3. Muscle wasting and Atrophy. 4. Morbid obesity. 5. Unspecified Osteoarthritis. <p>B. On 09/16/24 at 2:28 pm, during an interview with R #28, she stated that she is frustrated because staff enters her room without knocking. R #28 stated she has reported her concerns to the Administrator, but it continues to occur.</p> <p>C. On 09/19/24 at 10:14 am, during an interview with the Regional Social Services Consultant (RSSC), he stated his expectation is for all employees to knock on the door first, if the resident does not answer employees, they should look in to the room to ensure the resident is safe while verbally announcing themselves. He stated that residents should be alerted to people entering their rooms because it is a dignity issue as well.</p> <p>R #96</p> <p>(continued on next page)</p> | | |

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| <p>F 0561</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>D. On 09/17/24 at 9:23 am, during an observation of R #96, she had her oxygen tube (a tube that is connected to the oxygen concentrator that supplies oxygen for one to breathe) loosely attached to the rail on her bed with a white fabric. Licensed Vocational Nurse (LVN) #1 started to untie the white fabric from the tube while R #96 was repeatedly asking her to stop. R #96 stated to LVN #1 she prefers the tube to be attached to her bed, so it's not on the floor. R #96 explained to LVN #1 that she did not want the germs on the floor to get on the oxygen tube. LVN #1 proceeded to untie the white fabric allowing the oxygen tube to fall to the floor and then threw the white fabric in the trash can. R #96 was visibly upset and said, I don't know why they treat us like little kids, I don't want the tube on the floor, and she (LVN #1) thinks she can do whatever she wants to.</p> <p>E. On 09/20/24 at 9:26 am, during an interview with the Regional Nurse Coordinator, she stated her expectation would be for the nurse to listen to the resident and promote her choice, especially if there was not a health reason behind untying the fabric.</p> <p>50207</p> | | |

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| <p>F 0565</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>Honor the resident's right to organize and participate in resident/family groups in the facility.</p> <p>34439</p> <p>Based on interviews, the facility failed to ensure the grievances identified by the Resident Council (RC) were resolved and the resolutions communicated back to the RC committee. This deficient practice could likely affect all 95 residents who reside at the facility. If the staff is not ensuring RC grievances are responded to and resolutions are communicated back to the RC group, then residents are likely to feel that their concerns do not matter, and do not have any influence over changing issues identified by residents. The findings are:</p> <p>A. On 09/17/24 at 10:00 am, during an interview with the Resident's Council members [R #10, R #34, R #40, R #44, R #45, R #55, R #64, and R #70], they stated the facility discourages them from filing grievances and when they do file grievances the facility does not respond timely, if at all.</p> <p>B. On 09/18/24 at 11:25 am, during an interview with the Activity Director (AD), she stated she fills out the grievance forms and submits the forms to the appropriate department head for completion. She stated that she informs the residents of the outcome of the grievances but stated she cannot do that until she gets the forms back which has at times taken up to several weeks.</p> <p>C. On 09/19/24 at 10:24 am during an interview with the Regional Social Services Consultant (RSSC), he stated his expectation is for staff to:</p> <ol style="list-style-type: none"> 1. Assist residents to write a grievance if requested by a resident and submit to the Social Services department so the grievance can be logged for internal tracking purposes. 2. Social Services should then submit the grievance to the appropriate department head to be completed and submitted to the Administrator. 3. Residents involved with the grievance should be notified in writing and in a manner that they understand. 4. Then the grievance should be placed in the binder. <p>The RSSC stated that he was unsure if grievances or outcomes are discussed during resident council meetings, but stated they should be.</p> |

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| <p>F 0567</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p> | <p>Honor the resident's right to manage his or her financial affairs.</p> <p>34439</p> <p>Based on interviews the facility failed to ensure residents have ready and reasonable access to their money. This deficient practice could likely affect all 95 residents who reside at the facility. If the facility is not ensuring residents have access to their money, then residents are likely to feel undignified and unworthy. The findings are:</p> <p>A. On 09/17/24 at 8:42 am, during an interview with R #24, she stated she recently received a check for a large amount of money, but the facility will not give her any money. She stated the facility tells the residents that they've [the facility] ran out of money when money is requested. R #24 stated that the facility never gives out money on the weekends.</p> <p>B. On 09/17/24 at 10:00 am, during an interview with the Resident Council members [R #10, R #34, R #40, R #44, R #45, R #55, and R #64], they stated on weekdays, when they request money, staff have constantly told them that the money is not available. The residents further stated that they are never allowed to get money on the weekends.</p> <p>C. On 09/18/24 at 9:50 am, during an interview with the Business Office Manager (BOM), she stated the facility did receive a check for R #24 on 09/04/24, and the check was deposited the same day, and cleared (funds were available) on 09/05/24. The BOM confirmed R #24 requested money on 09/06/24 and the request was denied due to the facility not have any money available at that time. The BOM confirmed the facility did not have any cash on hand for the resident's use for a total of thirteen days (from September 5, 2024, to September 17, 2024).</p> <p>D. On 09/18/24 at 10:19 am, during an interview with the Regional Business Office Manager (RBOM), she stated her expectation is for the facility to have cash on hand for residents use at all times.</p> | | |

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| <p>F 0576</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p> | <p>34439</p> <p>Ensure residents have reasonable access to and privacy in their use of communication methods.</p> <p>Based on interviews, the facility failed to ensure that residents are able to receive mail on Saturdays for all 95 residents residing at the facility. This deficient practice is likely to result in residents not receiving timely communication which could result in feelings of isolation. The findings are:</p> <p>A. On 09/17/24 at 10:00 am, during the Resident's Council Meeting [R #10, R #34, R #40, R #44, R #45, R #55, R #64, and R #70], the residents stated mail is not delivered on Saturdays and they would like to receive their mail when it is delivered to the facility. R #44 stated she has never received her mail on a Saturday, even when she is waiting for a package. R #44 stated she has had to wait up to two days to receive packages that contain personal incontinence supplies.</p> <p>B. On 09/18/24 at 11:25 am, during an interview with the Activities Director (AD) she confirmed the mail is not delivered on the weekends. She stated she is the only staff at the facility that delivers the mail to residents. so if she is not at work, the mail does not get delivered.</p> <p>C. On 09/19/24 at 10:24 am during an interview with the Regional Social Services Consultant (RSSC), he stated he expects residents mail to be delivered daily.</p> | | |

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| <p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>Ensure each resident receives an accurate assessment.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49827</p> <p>Based on observation, interview and record review, the facility failed to complete an accurate comprehensive assessment for 2 (R #22 and R #75) of 2 (R #22 and R #75) residents reviewed for assessments. This deficient practice is likely to result in residents not receiving an accurate assessment which could result in the residents receiving less than optimal care and treatment. The findings are:</p> <p>R #22</p> <p>A. On 09/17/24 at 11:30 AM during an interview and observation with R #22, she stated she needed dental care but, she has not been offered a dental appointment. R #22 had missing teeth and discoloration.</p> <p>B. Record review of the Minimum Data Set (MDS) assessment dated [DATE], Section L: Oral and Dental Status indicated R #22 did not have any dental problems.</p> <p>C. On 09/20/24 at 1:52 PM during an interview with the MDS coordinator, he confirmed R #22's dental information was entered incorrectly.</p> <p>R #75</p> <p>D. On 09/17/24 at 9:43 AM during an interview with R #75, he stated he would like dentures, he further stated he has not had a dental appointment since prior to admission to the facility and would like dentures. He stated he might eat a little better if he did have dentures.</p> <p>E. Record review of the Minimum Data Set (MDS) assessment Quarterly dated 07/31/24, Section L: Oral and Dental Status revealed the section was not completed and left blank.</p> <p>F. On 09/20/24 at 1:52 PM during an interview with the MDS coordinator, he confirmed R #75 dental section was not completed.</p> |

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| <p>F 0679</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>Provide activities to meet all resident's needs.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34439</p> <p>Based on record review and interview, the facility failed to provide an ongoing program of activities designed to meet the interests for 4 (R #22, R #24, R #30, and R #90) of 6 (R #22, R #24, R #30, R #90, R #242, and R #294) residents reviewed for activities by not providing meaningful individualized activities based upon residents' interests. If residents are not provided or encouraged to attend/participate in activities that meets their interests, then they are likely to experience an increase in boredom, isolation, and depression. The findings are:</p> <p>R #22</p> <p>A. Record review of R #22's Admission Record revealed R #22 was admitted to the facility on [DATE] with multiple diagnoses including:</p> <ol style="list-style-type: none"> 1. Type 2 Diabetes Mellitus without complications (DM2, a condition results from insufficient production of insulin, causing high blood sugar). 2. Schizophrenia, unspecified (a disorder that affects an individual's ability to think, feel, and behave clearly). 3. Bipolar Disorder, unspecified (a disorder associated with episodes of mood swings ranging from depressive lows to manic highs). 4. Depression, unspecified (a mood disorder that causes a persistent feeling of sadness and loss of interest). 5. Persistent Mood [Affective] Disorder (continuous, long-term form of depression). 6. Anxiety Disorder, unspecified (a feeling of worry, nervousness, or unease, typically about an imminent event or something with an uncertain outcome). 7. Cerebral Palsy, unspecified (a disorder of movement, muscle tone, and posture). <p>B. On 09/16/24 at 2:45 pm, during an interview with R #22, she stated she does not know anything about the activities the facility offers. She stated the facility has not offered any activities or even discussed activities with her.</p> <p>C. Record review of R #22's Electronic Health Record (EHR) revealed the record did not contain any documentation of her participation in activities since she was admitted to the facility.</p> <p>D. On 09/18/24 at 11:30 am, during an interview with the Activity Director (AD), she confirmed she has not offered R #22 any activities, especially in room activities, since she knows that R #22 enjoys spending time in her room.</p> <p>R #24</p> <p>(continued on next page)</p> | | |

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| NAME OF PROVIDER OR SUPPLIER Casa Maria Healthcare | | STREET ADDRESS, CITY, STATE, ZIP CODE 1601 South Main Street Roswell, NM 88203 | |
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| <p>F 0679</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>E. Record review of R #24's Admission Record revealed R #24 was admitted to the facility on [DATE] with multiple diagnosis including:</p> <ol style="list-style-type: none"> 1. Unspecified Sequelae of Unspecified Cerebrovascular Disease (conditions that impact blood vessels in the brain). 2. Bipolar Disorder (a disorder associated with episodes of mood swings ranging from depressive lows to manic highs). 3. Anxiety Disorder. 4. Anoxic Brain Damage (damage to the brain from lack of oxygen), not elsewhere classified. 5. Difficulty in walking <p>F. On 09/17/24 at 8:40 am, during an interview with R #24, she stated that she does not attend activities because she has recently lost weight and does not have any clothes that fit her. She stated the facility has never offered activities for her to do in her room.</p> <p>G. On 09/18/24 at 11:04 am during an interview with the AD, she confirmed R #24 does not come out of her room very often. The AD stated R #24 does participate in room activities and stated all activities would be documented in R #24's Electronic Health Record.</p> <p>H. Record Review of R #24's EHR revealed the following:</p> <ol style="list-style-type: none"> 1. Note dated 07/08/24 stated R #24 was watching TV program in her room. 2. Note dated 07/18/24 stated R #24 was enjoying TV programs in her room. 3. Note dated 08/09/24 stated R #24 enjoyed activities in the dining room. 4. The EHR did not contain any additional documentation of R #24 participating in activities. <p>I. On 09/18/24 at 2:16 pm, during an interview with the AD, she stated that her expectation is for R #24 to participate in a wider variety of activities more often than she has. She stated that she expects more individualized activities be offered to residents.</p> <p>R #30</p> <p>J. Record review of R #30's Admission Record revealed R #30 was originally admitted to the facility on [DATE] and readmitted to the facility on [DATE] with multiple diagnoses including:</p> <ol style="list-style-type: none"> 1. Acute and Chronic Respiratory Failure with Hypercapnia (a condition that requires long-term regular care that can become an emergency with too much carbon dioxide in the blood). 2. Muscle weakness, generalized. 3. Difficulty in walking. <p>(continued on next page)</p> | | |

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| <p>F 0679</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>4. Polyneuropathy, unspecified (a condition where a person's nerves located outside of the brain and spinal cord are damaged).</p> <p>5. Hypertensive Heart Disease with heart failure.</p> <p>K. On 09/17/24 at 8:40 am during an interview with R #30, he stated he does not like to attend group activities, but would like to be offered activities that he can do in his room. He stated you [residents] have to go to activities, or you do not get activities at all.</p> <p>L. On 09/18/24 at 11:04 am during an interview with the AD, she confirmed R #30 has not been offered any activities since his readmission to the facility.</p> <p>R #90</p> <p>M. Record review of R #90's Admission Record revealed R #90 was admitted to the facility on [DATE] with multiple diagnosis including:</p> <ol style="list-style-type: none"> 1. Cellulitis of right lower limb. 2. Chronic Viral Hepatitis C. 3. Type 2 Diabetes Mellitus with Diabetic Chronic Kidney Disease. 4. Depression, unspecified. 5. End Stage Renal Disease. <p>N. On 09/17/24 at 9:05 am, during an interview with R #90, he stated he has not participated in any activities since he was admitted to the facility. He stated he did not know there were any activities offered and confirmed that nobody from the facility has talked with him about activities.</p> <p>O. Record review of R #90's EHR revealed the record did not contain any documentation of R #90 participating in activities.</p> <p>P. On 09/18/24 at 11:37 am during an interview with the AD, she confirmed she is the only staff member at the facility that meets with residents regarding activities, and she has not interacted with R #90 since his admission.</p> <p>46064</p> <p>49827</p> | | |

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| <p>F 0685</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>Assist a resident in gaining access to vision and hearing services.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46064</p> <p>Based on record review and interview, the facility failed to ensure residents received proper treatment to maintain vision for 1 (R #24) of 2 (R #24 and R #106) residents reviewed for vision. This deficient practice could likely result in residents losing some independence if they cannot see, and compromising their quality of life. The findings are:</p> <p>A. Record review of R #24's Admission Record revealed R #24 was admitted to the facility on [DATE] with multiple diagnosis including:</p> <ol style="list-style-type: none"> 1. Unspecified Sequelae of Unspecified Cerebrovascular Disease (conditions that impact blood vessels in the brain). 2. Bipolar Disorder (a disorder associated with episodes of mood swings ranging from depressive lows to manic highs). 3. Anxiety Disorder. 4. Anoxic Brain Damage (damage to the brain from lack of oxygen), not elsewhere classified. 5. Difficulty in walking <p>B. On 09/17/24 at 8:51 am, during an interview with R #24, she stated she needs eyeglasses because she can not see very well. R #24 further stated the previous Social Services Director told her an appointment would be scheduled but she is still waiting. R #24 stated this conversation with the previous Social Services Director happened a couple weeks after she was admitted but could not remember the date.</p> <p>C. On 09/19/24 at 10:43 am, during an interview with the Regional Social Services Consultant (RSSC), he confirmed he could not find anything regarding a vision appointment in R #23's Electronic Health Record. He stated, Now that we know, it will be scheduled.</p> |

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| <p>F 0728</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p> | <p>Ensure that nurse aides who have worked more than 4 months, are trained and competent; and nurse aides who have worked less than 4 months are enrolled in appropriate training.</p> <p>50207</p> <p>Based on record review and interview, the facility failed to provide documentation confirming on Nurse Aide (NA) #1, employed by the facility, had completed a Nurse Aide Training and Competency Evaluation Program (NATCEP) or a Competency Evaluation Program (CEP) within four months of being employed at the facility. This deficient practice is likely to affect all 95 residents residing in the facility. Residents are likely to experience substandard care because of the use of untrained or unqualified aides providing direct care to residents. The findings are:</p> <p>A. Record review of NA #1's personnel record reviewed the following:</p> <ol style="list-style-type: none"> 1. NA #1's hire date was 07/17/23. 2. NA #1's date of Certified Nurse Aide certification was 12/08/23. <p>B. On 09/20/25 at 11:55 am, during an interview with the Human Resources Director (HRD), she confirmed NA #1 received her certification late and continued to work shifts during that time. She stated her expectation is for all nurse aides to become certified within four months.</p> |

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| <p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>Ensure medication error rates are not 5 percent or greater.</p> <p>49827</p> <p>Based on observation, record review, and interview, the facility failed to ensure the medication error rate was 5% or less when six medication errors occurred out of 43 opportunities, which resulted in an error rate of 13.95% for 4 (R #19, R #24, R #55, and R #76) of 7 (R #19, R #24, R #38, R #41, R #55, R #62, and R #76) residents observed during medication administration. This deficient practice could likely result in the residents receiving the incorrect medication, not receiving the desired therapeutic effect, and exposing the resident to a higher risk of side effects. The findings are:</p> <p>Incorrect Administration</p> <p>A. Record review of the physician's order dated 09/17/24 for R #55, revealed an order for Lantus Subcutaneous solution (long-acting insulin that starts to work several hours after injection and keeps working evenly for 24 hours and is used to improve blood sugar control) 100 UNIT/ML (100 units of insulin per milliliter of solution) (insulin glargine [bioengineered (man-made) injectable form of long-acting insulin that is used to regulate sugar/glucose levels]) Inject 46 units subcutaneously (method of administering medication by injection into the tissue layer between the skin and the muscle) one time a day for DM 2 (DM 2, a condition results from insufficient production of insulin, causing high blood sugar), hold (medication) if blood glucose level is below <120 (A blood glucose test measures the level of glucose (sugar) in your blood in milligrams per deciliter. The test can involve a finger prick or a blood draw from your vein). [The preferred blood sugar range should be 70-100 mg/dl].</p> <p>B. On 09/18/24 at 7:58 AM, during an observation, Licensed Vocational Nurse (LVN) #2 withdrew 46 units of insulin from the insulin vial and administered the dose to R #55. LVN #2 did not hold insulin or blood glucose level below 120 mg/dl .</p> <p>Sanitizing hands Appropriately</p> <p>C. On 09/18/24 at 8:10 AM, during an observation of medication administration, License Practical Nurse (LPN) #1 failed to sanitize hands prior to preparing medications for R #19 and LPN #1 failed to sanitize hands after administration of medications to R #19.</p> <p>D. On 09/18/24 at 8:18 AM, during an observation of medication administration LPN #1 failed to sanitize hands prior to preparing and administering medications for R #76 and failed to sanitize hands after administration of medications.</p> <p>E. On 09/18/24 at 8:20 AM, during an observation of medication administration, LPN #1 failed to sanitize hands after administering medications to R #24.</p> <p>F. Record review of the Medication-Administration policy (not dated), provided by the Administrator (ADM) on 09/18/24, under the heading Procedure point number 2, wash hands before and after medication administration.</p> <p>(continued on next page)</p> | | |

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| <p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>G. On 09/20/24 at 9:22 AM, during an interview with Regional Nurse Coordinator (RNC), she stated staff should follow the physician orders and facility policy on how medications are given to residents, including washing hands before and after resident interactions</p> | | |

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| <p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>Ensure that residents are free from significant medication errors.</p> <p>49827</p> <p>Based on record review, observation and interview, the facility failed to ensure a resident was free of a significant medication error by not administering medications as ordered for 1 (R #55) of 1 (R #55) resident reviewed for administration of insulin (hormone produced in the pancreas which regulates the amount of glucose in the blood). This deficient practice could likely have severe negative effects on the resident, such as hypoglycemia (too little sugar in the blood) and lead to symptoms of trouble talking, confusion, loss of consciousness, seizures, or death. The findings are:</p> <p>A. Record review of R #55's Admission Record (no date) revealed the diagnosis of Type 2 Diabetes Mellitus (condition characterized by high blood glucose levels caused by either a lack of insulin or the body's inability to use insulin efficiently) with foot ulcer.</p> <p>B. Record review of R #55's Physician's Orders revealed an order dated 09/17/24 at 8:00 am Lantus Subcutaneous solution (long-acting insulin that starts to work several hours after injection and keeps working evenly for 24 hours and is used to improve blood sugar control) 100 UNIT/ML (100 units of insulin per milliliter of solution) (insulin glargine [bioengineered (man-made) injectable form of long-acting insulin that is used to regulate sugar/glucose levels]) Inject 46 units subcutaneously (method of administering medication by injection into the tissue layer between the skin and the muscle) one time a day for DM II (Type 2 Diabetes Mellitus), hold (medication) if below < (less than)120. [A blood glucose test measures the level of glucose (sugar) in your blood in milligrams per deciliter. The test can involve a finger prick or a blood draw from your vein]. [The preferred blood sugar range should be 70-100 mg/dl].</p> <p>C. On 09/18/24 at 7:58 AM, during an observation. Licensed Vocational Nurse (LVN) #2 withdrew 46 units of insulin from the insulin vial and administered 46 units to R #55. LVN #2 did not hold R #55's insulin as ordered when blood sugar levels are less than 120 mg/dl.</p> <p>D. On 09/18/24 at 7:58 AM, during an interview, LVN #2 confirmed that R #55's blood sugar level was 118 mg/dl when checked prior to giving the insulin.</p> <p>E. On 09/20/24 at 9:22 AM, during an interview with Regional Nurse Coordinator (RNC), she stated staff should follow the physician orders and facility policy on how medications are given to residents.</p> |

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| <p>F 0791</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>Provide or obtain dental services for each resident.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46064</p> <p>Based on observation, record review, and interview, the facility failed to ensure residents obtained routine dental care for 3 (R #22, R #24 and R #75) of 3 (R #22, R #24 and R #75) residents reviewed for dental services. This failure is likely to result in the resident experiencing pain, embarrassment over condition of teeth, and potential weight loss. The findings are:</p> <p>R#22</p> <p>A. Record review of R #22's face sheet revealed R #22 was admitted into the facility on [DATE].</p> <p>B. On 09/17/24 at 11:30 AM during an observation and interview with R #22, she had missing teeth, tooth decay and discoloration on the remaining teeth. R #22 stated, she had not been offered dental care. She stated she had some of her teeth pulled in the past and she wanted to get dentures.</p> <p>C. On 09/18/24 at 2:36 PM during an interview with Medical Records/Scheduler, she stated she schedules specialty services only and Social Services will make all other appointments for needs that are requested during care plan meetings or interdisciplinary team (IDT) meetings.</p> <p>D. On 09/19/24 at 10:08 AM during an interview with Regional Social Services Consultant (RSSC) confirmed R #22 had not been offered a dental appointment, but would get her scheduled.</p> <p>R #24</p> <p>E. On 09/17/24 at 8:50 AM during an interview with R #24, she stated my dentures were taken to be fitted about four weeks ago and I haven't heard anything about them.</p> <p>F. On 09/19/24 at 10:45 AM during an interview with the RSSC, she stated R #24's dentures should have been delivered during an appointment on 08/14/24. RSSC stated the medical records/scheduler (MR) should have followed up on that.</p> <p>G. Record review of R #24's Electronic Health Record revealed the record did not contain any documentation of a dental appointment on 08/14/24.</p> <p>H. On 09/19/24 at 2:46 pm during an interview with MR, she confirmed R #24 should have had a dental appointment to get her dentures in August 2024 and it did not occur. She stated I should have followed up on this appointment sooner and I didn't, I'll take the blame for it. I usually follow-up once a week.</p> <p>R#75</p> <p>I. Record review of R #75's face sheet revealed R #75 was admitted into the facility on [DATE] with a history of muscle wasting (weakening of muscle) and atrophy (decrease in size of muscle).</p> <p>(continued on next page)</p> | | |

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| <p>F 0791</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>J. On 09/17/24 at 9:43 AM during an observation and interview with R #75, he had missing teeth. R #75 stated, he had not had a dental appointment since he was admitted . He stated he has stomach problems which has caused weight loss but stated that if he had dentures, he may be able to eat better</p> <p>K. On 09/19/24 at 10:08 AM during an interview with the RSSC, he confirmed that an email dated 07/15/24 had been sent requesting a dental appointment for R #75, but confirmed that a follow up to that referral had not been completed and an appointment had never been made</p> <p>49827</p> | | |

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| <p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p> | <p>46064</p> <p>49827</p> <p>Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature.</p> <p>Based on interview and observation, the facility failed:</p> <ol style="list-style-type: none"> 1. Ensure meals were attractive when served to residents. 2. Ensure foods were palatable (pleasant to taste) and to the resident's satisfaction. 3. Ensure cold and hot foods were served at the appropriate temperatures to prevent scalding and burning. 4. Ensure foods were served timely to each resident and those sharing tables. <p>These deficient practices have the potential to affect all 95 residents' ability to eat and enjoy meals, may decrease their quality of life, and could likely lose weight.</p> <p>The findings are:</p> <p>Food Attractiveness</p> <p>A. On 09/16/24 at 3:51 pm, during an observation of R #90 in his room, he had a partially eaten hamburger on his bedside table. The meat was visibly red in the middle and appeared undercooked.</p> <p>B. On 09/16/24 at 3:51 pm, during an interview, R #90 stated he was asked during breakfast what he wanted for lunch and was offered chicken fried steak. When he arrived for lunch, they served him spaghetti. He was told by the staff that he could not have chicken fried steak, because it is not included on the anytime menu, but was offered a hamburger instead. R #90 stated he doesn't mind getting a hamburger, but it was too raw to eat.</p> <p>Food palatability</p> <p>C. On 09/16/24 at 12:36 pm during an interview with R #3, she stated she did not want to eat lunch because it's too hard. She stated she didn't like what was being served and was offered a grilled cheese, but the crust was too hard. So I told her (CNA who served her) to forget it. R #3 stated she is not offered an alternative meal choice and will purchase Nutra grain bars for when she doesn't like what is served.</p> <p>D. On 09/16/24 at 12:46 pm during an observation and interview with R #44, she was served grilled cheese sandwich and stated the cheese was not melted.</p> <p>E. On 09/17/24 at 8:41 am, during an interview with R #65, she stated the food is too spicy to her a lot of the time and she won't eat it like that. She stated she doesn't like to complain.</p> <p>(continued on next page)</p> | | |

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| <p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p> | <p>F. On 09/17/24 at 8:47 am during an interview with R #24, she stated the food, it's not good. I'm supposed to be on weight gain program. If you ask for the alternate meal a sandwich is all you get.</p> <p>G. On 09/17/24 at 9:11 am, during an interview with R #34, she stated the food taste is okay, but it depends on how the food is cooked and who is the cook. The food is either too cold or the meat is too tough.</p> <p>H. On 09/17/24 at 9:48 am, during an interview with R #75, he stated he doesn't tolerate the food when it is too spicy but doesn't like to complain and will eat what he can.</p> <p>I. On 09/17/24 at 12:43 pm, during an interview with R #242, he stated the food does not taste good and stated he does not eat it the food when it is too spicy.</p> <p>J. On 09/19/24 at 11:43 am, during an interview with Dietary Manager (DM), he stated he was not aware the residents complained the food is too spicy. He stated when he is made aware of any issues, he will make those adjustments. He stated, for example, he did have complaints about the sausage being spicy and he changed the sausage to the mild brand. The DM stated he can and will make adjustments if needed, as long as he is made aware.</p> <p>K. On 09/19/24 at 11:30 am during an interview with the DM, he stated meal choices should be made clear to the residents including the optional sides [hamburger with fries, vegetables, or chips].</p> <p>L. On 09/20/24 at 12:33 am, during an on observation of a test tray, the test tray was brought from the kitchen. The meal was shredded chicken, white bread, green beans, and mashed potatoes with gravy. The temperature of chicken was 95F degrees. Food tasted good, potatoes were unsalted and bland without the gravy.</p> <p>Food Temperature</p> <p>M. On 09/17/24 at 9:11 am, during an interview with R #34, she stated the food taste depends on who cooked the food, whether the food is too cold or the meat is too tough.</p> <p>N. On 09/17/24 at 12:43 pm, during an interview with R #242, he stated the food is always cold and does not taste good.</p> <p>O. On 09/19/24 at 4:51 pm, during an observation of kitchen staff preparing to move hot foods on a heated transport carrier to the pilot kitchen. The temperature of the tomato soup was 115 degrees Fahrenheit and had to be reheated. When the tomato soup was returned to heat cart the soup was 200 degrees Fahrenheit. Kitchen Staff (K) #3, was asked what proper holding temperatures should be and he was unable to provide the appropriate holding food temperatures.</p> <p>P. On 09/19/24 at 11:30 am, during an interview with the DM, he stated his expectation is for the individual food items should be temperature checked before being served and food should have been cooked correctly and held at the correct temperature.</p> <p>Food Timing</p> <p>(continued on next page)</p> |

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| NAME OF PROVIDER OR SUPPLIER Casa Maria Healthcare | | STREET ADDRESS, CITY, STATE, ZIP CODE 1601 South Main Street Roswell, NM 88203 | |
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| <p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p> | <p>Q. Record review of posted mealtimes on 09/16/24 at 12:30 pm indicated lunch was to be served starting at 11:30 am through 1:30 pm.</p> <p>R. On 09/16/24 at 12:04 pm, during the lunch dining observation, the first meal was served at 12:22 pm to R #12, at the same table R #56 was served his meal at 12:29 pm, R #64 received his meal at 12:34 pm and R #70 received meal at 12:40 pm.</p> <p>S. On 09/16/24 at 12:30 pm, during lunch dining observation, staff served the meal trays to the table where R #2 and R #27 sat, and they were served their meal at the same time. R #58, who was also at the same table, received their meal at 12:45 pm, 15 minutes after the first two residents were served.</p> <p>T. On 09/16/24 at 12:35 pm, during a lunch dining observation, R #1 was served his meal at 12:35 pm and R #40, who was also at the same table, received their meal at 12:50 pm, 15 minutes after the first person at the table was served their meal.</p> <p>U. On 09/19/24 at 11:12 am, during an interview with DM, he confirmed that residents who are sitting at the same table should be served at or around the same time, he stated that 13 minutes is too long. The timing for last resident at 13 minutes apart would receive their meal almost an hour after the first resident at the table received their meal.</p> | | |

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| <p>F 0809</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p> | <p>Ensure meals and snacks are served at times in accordance with resident's needs, preferences, and requests. Suitable and nourishing alternative meals and snacks must be provided for residents who want to eat at non-traditional times or outside of scheduled meal times.</p> <p>49827</p> <p>Based on record review and interview, the facility failed to ensure the nutritional needs and preferences were met for all 95 residents listed on the facility census provided by the Administrator on 09/16/24 by not having an alternative meal available for residents.</p> <p>If the facility is not providing an alternative meal or offering an alternate meal menu to residents, then residents are likely to experience weight loss, frustration, and depression. The findings are:</p> <p>A. Record review of the posted menu for September 2024, indicated only one meal option for breakfast, lunch and dinner. The facility did not offer an alternative meal/choice (second meal option) for each meal, that is equal in nutritional value to the primary meal being served to all residents.</p> <p>B. On 09/19/24 at 11:17 am during an interview with the VPN (Vice President of Nutrition) she stated there is an always available menu. When asked if it was equivalent to the nutritional value of the main scheduled meal, she stated she feels the everyday menu may have different calories, but feels the resident has the choice to eat to peanut butter sandwich. She then stated the always available menu is not equal in nutritional value to the main meal served.</p> <p>C. On 09/19/24 at 11:43 am during an interview with the Dietary Manager (DM), he stated. There should be two meal options. One would be the meal offered and the other would be the alternative meal. An always available menu [ie. grilled cheese, peanut butter and jelly sandwich, salad, hamburger, etc .] is offered, but it is not like the main meal that is served.</p> | | |

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| <p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p> | <p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>49827</p> <p>Based on record review, observation and interview, the facility failed to store and serve food under sanitary conditions by not ensuring:</p> <ol style="list-style-type: none"> 1. Kitchen was clean and sanitary. 2. Food items labeled and dated 3. Refrigeration unit was clean. 5. Food storage and handling. 6. Maintenance of kitchen equipment and plumbing <p>These deficient practices are likely to affect all 95 residents listed on the resident census list provided by the Administrator on 09/16/24 and could likely lead to foodborne illnesses in residents if food is not being stored properly, safe food handling practices are not adhered to and sanitation of equipment preparation areas are not cleaned appropriately.</p> <p>The findings are:</p> <p>A. On 09/16/24 at 12:03 pm, during an observation of the initial tour of the kitchen and pilot kitchen from 12:03 pm through 12:33 pm, the following was revealed:</p> <ol style="list-style-type: none"> 1. The floor was sticky. 2. The kitchen sink near preparation area had hard water deposits around the spicket. 3. The ice machine had hardwater stains on the outside near door opening. 4. A visibly soiled rag laid in the corner of dishwasher area. 5. A visibly soiled area on the floor by the wall between ice machine and mobile shelving unit and also the corners of kitchen floor. 6. In the dishwashing room, off of the kitchen, contained 2 large sinks; the sink closest to the wall the floors were very wet and had large solid food pieces underneath the sink. 7. The eye wash station was soiled with a dark brown substance on inside and the outside. 8. A transfer cart near the clean dishes was dirty with food particles. 9. Sanitation buckets used for cleaning prep areas had dirty water and lacked sanitizing solution. <p>(continued on next page)</p> |

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| <p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p> | <p>B. On 09/16/24 at 12:03 pm, during observation and interview with Dietary Manager (DM), he was asked to check the sanitizer bucket with the approved test strips to ensure they had sanitizer in the buckets to wash the counter tops and any preparation food areas. The DM tested the sanitizer levels with the approved test strips the buckets and the bucket did not have any sanitizer present. DM confirmed that there should always be sanitizer present in the buckets used to wipe down any food prep areas and the buckets should be changed every two hours.</p> <p>C. On 09/16/24 at 12:05 pm, during observation of dishwashing area, the faucets add hard water deposits around the faucet, the faucet also to had a small steady flow. DM attempted to turn off the faucet completely and confirmed the faucet closed tightly. Plastic piping under the sink poured contents from the sink directly onto the floor and was supported by plastic container.</p> <p>D. On 09/16/24 at 12:08 pm, during an observation of the DM, he went to janitor closet to retrieve sanitizer for cleaning buckets, he found the 5-gal refill container of sanitizer was empty and dry. The DM stated at that time those conditions were unacceptable.</p> <p>E. On 09/19/24 at 4:32 pm, during an interview with the kitchen staff (KS) #3 and #4, they were asked to check the sanitizing solution contents of the red cleaning bucket. KS #3 and KS #4 attempted to check the solution in the cleaning bucket, when they were unsuccessful the DM informed them they were using the wrong testing strips, the DM at that point took over and tested the contents and confirmed that there was no sanitizing solution in the cleaning bucket.</p> <p>F. On 09/19/24 at 4:32 pm, during an interview with the DM, he confirmed the cleaning bucket did not contain the appropriate amount of sanitizing solution.</p> <p>G. Record review on of the Service Opening and Closing monitoring logs [AM/PM checklist facility uses to check refrigerator temps, turn on equipment, prepare sanitizing solution for prep areas, sanitize ice scoop, empty trash, sweep and mop floors, daily cleaning, label, date and store ingredients, empty and clean 3-compartment sink, empty and clean sanitizer buckets, place all soiled linens in appropriate receptacle], were not completed for 09/15/24 morning and evening and 09/16/24 am shift.</p> <p>Food Items Labeled and dated.</p> <p>H. On 09/16/24 at 12:06 pm, during observation of the kitchen food prep area, food items on the transportation racks of mobile cart were not labeled and dated.</p> <p>I. On 09/16/24 at 12:11 pm, during an interview with the DM, he confirmed Everything in the fridge should be labeled and dated.</p> <p>J. On 09/19/24 at 4:40 pm, during an observation of the kitchen refrigerator, the evening snacks were not dated and labeled.</p> <p>Refrigerator Clean and Sanitary</p> <p>K. On 09/16/24 at 12:11 pm, during an observation of the refrigerator the inside of the refrigerator had a blue plastic elevated platform that was covered with soiled dark substance.</p> <p>(continued on next page)</p> | | |

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| <p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p> | <p>L. On 09/16/24 at 12:11 during an interview the DM confirmed the blue platform is used to store food items off the floor and should be cleaned. He further confirmed the refrigerator, freezer and kitchen were not clean.</p> <p>Food Storing and Handling Properly</p> <p>M. On 09/16/24 at 12:21 pm, during an observation of the of pilot kitchen located in dining room, uncovered and unwrapped ham and cheese sat on the counter to the left of the steam table, ham and cheese was at room temperature.</p> <p>N. On 09/16/24 at 12:21 pm during an interview with KS #2 confirmed the ham and cheese should be kept on ice.</p> <p>O. On 09/16/24 at 12:27 pm, during continued observation of pilot kitchen, KS #1 dropped a resident's food ticket into the contents of the chicken on the steam table and proceeded to serve the chicken.</p> <p>P. On 09/16/24 at 12:27 pm, during an interview with KS #1, he was asked, if it is okay to serve the chicken now that it is contaminated. KS #1 stated he was unsure and contacted the DM. The DM arrived to confirm it was not fit to serve the chicken.</p> <p>Maintaining Faucets, Pipes, and Dishwasher</p> <p>Q. On 09/19/24 at 4:35 pm, during an observation of the kitchen, the middle sink by dishwasher had a red plumbing line leaking heavily onto the floor and created a large wet area throughout dishwashing area.</p> <p>R. On 09/19/24 at 4:36 pm, during an observation of the dishwasher, the dishwasher temperature wash cycle was 115 degrees Fahrenheit. The temperature should be 120 degrees Fahrenheit. The sanitizing solution measured less than 50 parts per million (PPM) should be 150-200 PPM, the sanitizing solution in use under dishwasher was visibly low.</p> |

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| <p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>Provide and implement an infection prevention and control program.</p> <p>49827</p> <p>Based on observation, interview, record review, the facility failed to administer medications in a manner to prevent cross contamination for 3 (R #19, R #24, and R #76) of 7 (R #19, R #24, R #38, R #41, R # 55, R #62, and R #76) residents. The failure has the potential to cause residents to be exposed to pathogens (organisms that can cause disease) and increased risk of infection.</p> <p>The findings are:</p> <p>A. On 09/18/24 at 8:05 am, during an observation of the medication administration pass, Licensed Practical Nurse (LPN) #1 prepared and gave R #19's medication and went back to the medication cart after administering medications. LPN #1 did not sanitize or wash her hands before or after resident contact.</p> <p>B. On 09/18/24 at 8:18 AM, during continued medication administration observation, LPN #1 prepared medications for R #76. R #76's medications included a subcutaneous (just under the skin) injection. LPN #1 entered the resident's room, donned (to put on) gloves and administered the resident her medications. LPN #1 removed gloves and exited the room. LPN #1 went back to the medication cart without sanitizing or washing her hands prior to or after the medication administration.</p> <p>C. On 09/18/24 at 8:20 AM, during continued medication administration observation, LPN #1 prepared medications for R #24. LPN #1 prepared and administered R #24 medications. LPN #1 went back to the medication cart without sanitizing or washing her hands after medication administration.</p> <p>D. On 09/18/24 at 9:43 AM, during an interview with the Director of Nursing (DON), she stated hand sanitizer should be used before and after contact with each resident. She stated that medications should be administered according to the facility policy. The DON stated if injections are given her expectation is to wear gloves and use good hand hygiene before and after injection administration.</p> <p>E. Review of the facility's policy titled, Medication-Administration (no date indicated), stated under the heading Procedure:</p> <ol style="list-style-type: none"> 1. Assemble the necessary equipment. 2. Wash hands before and after medication administration. 3. Gloves will be worn to administer medications when contact with blood or potentially infectious body fluid is anticipated. | | |

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| <p>F 0883</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>Develop and implement policies and procedures for flu and pneumonia vaccinations.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49827</p> <p>Based on record review the facility failed to ensure the medical records contained documentation that each resident received, or staff offered the pneumococcal (a bacteria that can cause pneumonia infection of the respiratory tract) or influenza (flu) vaccines for 1 (R #74) of 6 (R #2, R #17, R #22, R #39, R #74, and R #75) residents reviewed for immunizations. If residents are not vaccinated as appropriate against pneumonia and influenza, they have a higher likelihood of contracting that illness and spreading it to other 95 residents on the census list provided by Administrator (ADM) on 09/16/24 and staff in the facility.</p> <p>The findings are:</p> <p>A. Record review of R #74's medical record revealed the following:</p> <ol style="list-style-type: none"> 1. Admission record for R #74 indicated she was admitted to the facility on [DATE]. 2. Review of the EHR (Electronic Health Record) did not contain consent forms or declination forms for either vaccination. 3. Record review of the facility's policy titled Influenza Prevention and Control (no date) are to be offered to the residents after education is received. <p>B. Record review of the facility's police titled Pneumococcal Disease Prevention (no date) are to be offered to residents after education is received.</p> |

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| <p>F 0947</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention.</p> <p>50207</p> <p>Based on record review and interview, the facility failed to ensure Certified Nurse Aides (CNAs) received the required in-service training of 12 hours per year for 1 (CNA #1) of 2 (CNA #1 and CNA #2) CNAs reviewed for required in-service training. This deficient practice is likely to result in the CNAs not receiving the necessary training to meet the care needs of the residents. The findings are:</p> <p>A. Record review of CNA #1's personnel file revealed CNA #1 was hired on 06/27/23.</p> <p>B. Record review of CNA #1's in-service training Transcript Report revealed CNA #1 did not complete any of the required 12 hours trainings from 06/27/23 to 09/20/24.</p> <p>C. On 09/20/24 at 11:55 am, during an interview with the Human Resources Director (HRD), she confirmed CNA #1 has not completed any trainings during her employment at the facility. She confirmed CNA #1 continues to work shifts providing care for residents in the facility even though she has not completed any of the trainings. The HRD stated she expected all CNAs to complete at least 12 hours of training per year.</p> | | |