

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 325091	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/28/2025
NAME OF PROVIDER OR SUPPLIER Silver City Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 3514 Fowler Ave Silver City, NM 88061	

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 0550</p> <p>Level of Harm - 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>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47510</p> <p>Based on record review and interview, the facility failed to ensure residents had a right to a dignified existence and were treated with respect and dignity for 1 (R #16) of 3 (R #1, R #16, and R #17) residents when facility staff used R #16 (without consent) to play a prank/joke on another staff member after R #16 was deceased . This deficient practice was disrespectful and dehumanizing to R #16 and her family. The findings are:</p> <p>A. Record review the admission record revealed R #16 was initially admitted on [DATE].</p> <p>B. Record review of Physician Orders revealed that R #16 was full code (medical term indicating patient wishes to receive all possible life saving measures in the event of a medical emergency).</p> <p>C. Record review of R #16's progress notes dated [DATE] revealed:</p> <p>1. 2205 (10:05 pm) resident assessed during hourly rounds. Semifowler (position of laying in bed on back with head and torso raised between ,d+[DATE] degrees) in bed, room in good order no issues whatsoever resident unresponsive to when called out attempting to arouse. Assess results radial pulse weak thready faintly palpable (to be felt). Visible respiration inadequate to sustain life due to rate of 4 -8 per minute. Code blue initiated. Code blue called out, crash cart obtained, 911 call for assistance from emergency response teams. CPR (cardiopulmonary resuscitation) protocol breaths and chest compression provided 2208 (10:08 pm). 2211(10:11 pm) patient assessment resulting in no detectable heart beat, respirations, CPR resumption at which time ems entered room and immediately deployed team in rendering/continuing care. At this time care center employees and this nurse removed ourselves from that role.</p> <p>2. Progress note identified notification to next of kin (Son #1) and he indicated that he would need to contact Son #2 to get funeral information. Per progress note dated [DATE] at 5:44 am, still waiting on funeral information.</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
---	-------	-----------

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 325091	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/28/2025
NAME OF PROVIDER OR SUPPLIER Silver City Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 3514 Fowler Ave Silver City, NM 88061	
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 0550 Level of Harm - Actual harm Residents Affected - Few	<p>D. On [DATE] at 4:36 PM, during an interview, NA #1 said she arrived at work on [DATE] at 6:00 AM and at 6:30 AM, RN #1 asked her to go take R #16's vital signs (measurements of the body's essential functions). NA #1 said when she went into R #16's room and usually R #16 would respond to her right away when entering her room but this time she did not. NA #1 said R #16's dentures did not seem to be sitting right in her mouth and R #16 did not respond to her. NA #1 stated she nudged R #16 and noticed she was cold. NA #1 said she realized R #16 had passed away. NA #1 said she thought R #16 had just passed away, so she left the room to let staff know, and RN #1 was standing outside R #16's room laughing. RN #1 stated that it was a cruel rookie joke that he was playing on her. RN #1 told NA #1 not to say anything because he wanted to play the same joke on another staff. NA #1 said that she was so distraught after the incident that eventually emergency medical services had to be called because she was having a panic attack.</p> <p>E. On [DATE] at 6:57 PM, during an interview, CNA #1 stated R #16 passed away on [DATE] at 10:56 PM. CNA #1 said RN #1 wanted to play a joke on NA #1 (RN #1 is the night shift manager on the unit). CNA #1 said that when NA #1 got to work on [DATE], RN #1 told NA #1 to go take R #16's vital, knowing that R #16 was deceased . CNA #1 confirmed that she did not try to prevent the prank.</p> <p>F. On [DATE] at 7:16 PM, during an interview, NA #2 said that R #16 had passed away and RN #1 wanted to play a joke on staff. NA #2 said when NA #1 got to work around 6:00 am on [DATE], she heard RN #1 ask NA #1 to go take R #16's vital signs. NA #2 said the joke was supposed to be played on another coworker too, but that the other coworker did not report to work.</p> <p>G. On [DATE] at 12:01 PM, during an interview, Unit Manager (UM) #1 said she arrived at work on [DATE] at 6:00 am. UM #1 said she did not witness the prank that was played on NA #1, but was told about the joke after it happened. UM #1 did not remember who told her. UM #1 said she did not know whose idea it was to play the joke. UM #1 said she was told that someone was told to take vitals on a resident that was deceased .</p> <p>H. On [DATE] at 12:07 PM, during an interview, the Administrator said R #16 passed away during the night. The Administrator said that the morning ([DATE]) after R #16 passed, RN #1 told NA #1 to go check vitals on a resident that had already passed. The Administrator said RN #1 wanted to use the passing of R #16 as a teaching opportunity to see what NA #1 would do if a resident passed away. The Administrator said that she was not told that it was meant to be a joke. The Administrator said that she received an email from NA #1's family member later on [received on [DATE]] informing her of what was done to NA #1 was a joke. During the interview, the Administrator reported that she did not believe that there was any effect to R #16 because she was already deceased when it happened.</p> <p>I. Record review of CMA #1's written statement dated [DATE], revealed NA #1 was asked to take R #16's vitals and R #16 had already passed away and checking the vital signs was as a friendly joke.</p> <p>J. Record review of SSD's written statement dated [DATE], revealed NA #1 told her that she was asked to get R #16's vitals, and R #16 was already dead. SSD said that NA #1 stated she was freaked out really bad by what had happened.</p> <p>K. On [DATE], three attempts were made to contact RN #1 for an interview. RN #1 did not answer, voicemails were left, and RN #1 did not return any of the calls.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 325091	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/28/2025
NAME OF PROVIDER OR SUPPLIER Silver City Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 3514 Fowler Ave Silver City, NM 88061	
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 0550 Level of Harm - Actual harm Residents Affected - Few	L. On [DATE] at 4:13 PM, during an interview with R #16's son (Son #2), he said that R #16 would have been horrified that a staff member was sent into her room after she had passed away to check her vitals as a prank. Son #2 said it was disgusting that they [staff] did that to his mother.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 325091	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/28/2025
NAME OF PROVIDER OR SUPPLIER Silver City Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 3514 Fowler Ave Silver City, NM 88061	
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 0610</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47510</p> <p>Based on record review and interview, the facility failed to thoroughly investigate an allegation of abuse/mistreatment for 1 (R #16) of 3 (R #1, R #16, and R #17) residents reviewed when they failed to:</p> <ol style="list-style-type: none"> 1. Identify that staff using a deceased resident to carry out a prank/joke on another staff member was abuse/mistreatment of the resident. 2. Thoroughly investigate all components of the allegation. 2. Prevent further abuse/mistreatment by not removing RN #1 [initiator of the prank] from resident care. 3. Initiate corrective action to ensure staff are not dehumanizing residents and continue to treat residents with respect even after they are deceased . <p>If the facility is not adequately investigating allegations of abuse, then corrective action is not implemented to prevent other residents from similar abuse which puts residents at risk of adverse serious outcomes. The findings are:</p> <p>Cross Reference findings from F550</p> <p>A. Record review the admission record revealed R #16 was initially admitted on [DATE].</p> <p>B. Record review of Physician Orders revealed R #16 was full code (medical term indicating patient wishes to receive all possible life saving measures in the event of a medical emergency).</p> <p>C. Record review of R #16's progress notes dated [DATE] revealed:</p> <ol style="list-style-type: none"> 1. 2205 (10:05 pm) resident assessed during hourly rounds. Semifowler (reclining position with head and torso raised between ,d+[DATE] degrees) in bed, room in good order no issues whatsoever resident unresponsive to when called out attempting to arouse. Assess results radial pulse weak faintly palpable (to be felt). Visible respiration inadequate to sustain life due to rate of 4 -8 per minute. Code blue initiated. Code blue called out, crash cart obtained, 911 call for assistance from emergency response teams. CPR (cardiopulmonary resuscitation) protocol breaths and chest compression provided 2208 (10:08 pm). 2211(10:11 pm) patient assessment resulting in no detectable heart beat, respirations, CPR resumption at which time ems entered room and immediately deployed team in rendering/continuing care. At this time care center employees and this nurse removed ourselves from that role. 2. Progress note identified notification to next of kin (Son #1) and he indicated that he would need to contact Son #2 to get funeral information. Per progress note dated [DATE] at 5:44 am, still waiting on funeral information. <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 325091	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/28/2025
NAME OF PROVIDER OR SUPPLIER Silver City Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 3514 Fowler Ave Silver City, NM 88061	
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 0610</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>D. On [DATE] at 4:36 PM, during an interview, NA #1 stated she got to work on [DATE] at 6:00 am. NA #1 said that she noticed R #16's door was closed, and the door being closed was unusual. NA #1 said that at 6:30 AM, RN #1 [night shift manager] asked her to take R #16's vital signs. NA #1 stated when she went into R #16's room, the room was cold. NA #1 said R #16 would usually respond to her right away when entering the room. NA #1 said R #16's dentures did not seem to be sitting right in her mouth. NA #1 further stated that she nudged R #16 and noticed at that time she was cold. NA #1 stated she realized R #16 had passed, so she left the room to let staff know and RN #1 was standing outside the room laughing. NA #1 stated RN #1 said it was a cruel rookie joke that he was playing and RN #1 told NA #1 not to say anything because he wanted to play the joke on another staff member. NA #1 said that she was so distraught that emergency medical services had to be called to check her out because she was having a panic attack.</p> <p>E. On [DATE] at 12:07 PM, during an interview, the Administrator said she is the abuse coordinator. The Administrator stated R #16 passed during the night on [DATE] at 10:56 PM. The Administrator said RN #1 told NA #1 to go check vitals on R #16 who had already passed. The Administrator said RN #1 used the passing of R #16 as a teaching opportunity to teach NA #1 what to do when someone passes away. The Administrator further stated she was not told what happened to NA #1 was a joke/prank and she did not report the incident to the state because she thought it was a staff thing. The Administrator stated she received an email from [Name of NA #1's] family member [on ,d+[DATE]] informing her that NA #1 was sent to R #16's room after she had passed away, was a joke and only after she received the email did she initiate an investigation [[DATE]]. The Administrator investigated the incident as the facility not performing proper postmortem care because the emailed mentioned that when NA #1 entered the room to take vitals, she noticed that R #16's dentures were free floating in her mouth. The Administrator further stated that RN #1 was not suspended because he was scheduled to be off the days following the incident (RN #1 was still working in the facility until [DATE]. See plan of removal.) RN #1 received a written reprimand for sending NA # 1, to get vitals on a deceased resident (R #16). The Administrator did not document any reprimand for disrespecting a deceased resident. During the interview, the Administrator reported that she did not believe that there was any effect to R #16 because she was already deceased when it happened. The Administrator confirmed that there was not any education for RN #1 or other staff regarding respecting deceased residents.</p> <p>F. Record review of the facility's self report dated [DATE] identified Care concerns have been reported for this resident [R #16]. Investigation started.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 325091	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/28/2025
NAME OF PROVIDER OR SUPPLIER Silver City Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 3514 Fowler Ave Silver City, NM 88061	
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 0610</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>G. Record review of the follow-up report dated [DATE] revealed On [DATE] an email was sent to [Corporate name] legal department about allegations of possible mistreatment of a resident after she passed. The lady writing the email claimed to be the mother of one of our nursing assistants and this lady made accusations that her daughter told her that the residents dentures didn't look quite right when she was sent in the room by her charge nurse. Her daughter worked here as a nursing assistant and was working that AM shift after [Name of R #16] had passed away. An investigation was started and the NOC (night) shift were interviewed about the post mortem care done for [Name of R #16] after she passed away on the NOC shift. The nurse on shift and the CNA on shift both stated they did the care together and [Name of R #16]'s dentures were removed during this care and placed in a denture cup to be sent to the mortuary with her. An AM shift CNA that helped the mortuary staff transfer her to their gurney supported their statement and said she gave the mortuary staff her dentures that had been sitting on the bedside table. Future Preventative Actions included Spot checks performed by the charge nurses to ensure the CNA's are performing proper postmortem care. No additional evidence was provided to include acknowledgement of the prank, any reprimand to the staff member who initiated the prank or any staff education to staff involved or aware of the incident related to mistreatment of the resident.</p> <p>H. Record review of the individual performance improvement plan date [DATE] revealed that the policy violation was RN #1 should not have told NA #1 to do vitals on a dead resident. It states that NA #1 could not handle it and that some people cannot handle, especially a young person that has not dealt with death before. The expected result was to not do it again. The developmental process was that death is a serious thing for people to deal with and it's not something that comes naturally. The measurement of expected results were that this will not happen again. Target date for the improvement was immediately.</p> <p>I. Record review of the Abuse Prohibition Policy dated [DATE], revealed the following:</p> <ol style="list-style-type: none"> 1. Suspected abuse will be reported to immediately. 2. The employee alleged to have committed the act of abuse will be immediately removed from duty, pending investigation. <p>J. On [DATE], three attempts were made to contact RN #1 for an interview. RN #1 did not answer, voicemails were left, and RN #1 did not return any of the calls.</p> <p>The above findings resulted in an Immediate Jeopardy that was called on [DATE] at 4:55 PM.</p> <p>The facility submitted a final plan of removal on [DATE] at 4:45 PM and the IJ was lifted, implementation was verified onsite. Training was reviewed, staff were interviewed and policy verified. Abuse Prohibition Policy was obtained and reviewed. Scope and Severity was reduced to level 2, D.</p> <p>Plan of Removal .The following identification/corrections will be completed by [DATE]:</p> <p>-The Administrator and DON were re-educated on [DATE] through [DATE] by the Market level staff, including the Market President special projects, Market Operation Advisor, Market Clinical Advisor, The training was on the policy and procedures for resident abuse and neglect with an emphasis on allegations of abuse being identified, immediate interventions put in place to prevent reoccurrence, immediately reporting to the appropriate state agencies, thorough investigation, and resident rights.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 325091	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/28/2025
NAME OF PROVIDER OR SUPPLIER Silver City Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 3514 Fowler Ave Silver City, NM 88061	
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 0610</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>-A full investigation occurred within the facility to ensure no other residents have been mistreated or have felt they were treated undignified was completed by [DATE]. Residents that are alert and able to answer questions were asked if they felt they had been treated in an undignified manner. The residents that are unable to answer appropriately or fully, their families/POA's (Power of Attorney the authority to act for another person in specified or all legal or financial matters) or guardians were called and asked the same question. If any further mistreatment or undignified treatment is identified, the facility will remove any resident from the situation, and proper monitoring and interventions will be initiated immediately upon notification. No new allegations were identified or alleged during the interview process.</p> <p>-If any staff are identified in an allegation of abuse, neglect, undignified behavior or mistreatment, the staff member will be removed from the situation to ensure resident safety and dignity, and the staff member will immediately be placed on administrative leave until the investigation is completed.</p> <p>-On [DATE] the identified RN of concern was placed on administrative leave pending the investigation. The RN's last scheduled work day in the facility was on [DATE] and on [DATE] RN was placed on Admin leave. Should the RN be allowed to return to work following the investigation; additional retraining will be offered by the Administrator and DON along with New Mexico Market level clinical leads under the guidance of corporate legal/risk/compliance staff on ensuring resident dignity and treating co-workers with respect and with a monitoring plan in place to ensure this does not recur.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 325091	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/28/2025
NAME OF PROVIDER OR SUPPLIER Silver City Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 3514 Fowler Ave Silver City, NM 88061	
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 0623</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights.</p> <p>47510</p> <p>Based on record review and interview, the facility failed to ensure residents, their representatives, and the Ombudsman received a written notice of transfer as soon as practicable for 4 (R #8, R #9, R #11 and R #13) of 4 (R #8, R #9, R #11 and R #13) residents reviewed for hospitalization . This deficient practice could likely result in the resident and/or their representative not knowing the reason or location the resident was discharged . The findings are:</p> <p>R #8</p> <p>A. Record review of R #8's medical record revealed the following:</p> <ol style="list-style-type: none"> 1. On 12/07/24, the facility transferred R #8 to the hospital for a fall. 2. On 12/08/24, the facility transferred R #8 to the hospital for evaluation of abdominal wound and fever 3. The record did not contain any written transfer notices. <p>R #9</p> <p>B. Record review of R #9's medical record revealed the following:</p> <ol style="list-style-type: none"> 1. On 12/09/24, R #9 was sent to the hospital for abnormal lab results. 2. The record did not contain a written transfer notice. <p>R #11</p> <p>C. Record review of R #11's medical record revealed the following:</p> <ol style="list-style-type: none"> 1. On 12/22/24, R #11 was sent to the hospital for fall. 2. The record did not contain a written transfer notice. <p>R #13</p> <p>D. Record review of R #13's medical record revealed the following:</p> <ol style="list-style-type: none"> 1. On 09/14/24, R #13 was sent to the hospital for altered mental status. 2. The record did not contain a written transfer notices. <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 325091	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/28/2025
NAME OF PROVIDER OR SUPPLIER Silver City Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 3514 Fowler Ave Silver City, NM 88061	

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 0623</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>E. On 01/08/25 at 2:55 PM, during an interview, the DON confirmed R #8, R #9, R #11, and R #13 did not have any transfer notices. The DON said that transfer notices should be done at the time of transfer or as soon as practicable.</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 325091	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/28/2025
NAME OF PROVIDER OR SUPPLIER Silver City Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 3514 Fowler Ave Silver City, NM 88061	
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 0625</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave.</p> <p>47510</p> <p>Based on record review and interview, the facility failed to ensure residents or their representatives received a written notice of the bed hold policy which indicated the duration the bed would be held for 4 (R #8, R #9, R #11 and R #13) of 4 (R #8, R #9, R #11 and R #13) residents reviewed for hospitalization . This deficient practice could likely result in the resident and/or their representative being unaware of the bed hold policy upon return from the hospital. The findings are:</p> <p>R #8</p> <p>A. Record review of R #8's medical record revealed the following:</p> <ol style="list-style-type: none"> 1. On 12/07/24, the facility transferred R #8 to the hospital for a fall. 2. On 12/08/24, the facility transferred R #8 to the hospital for evaluation of abdominal wound and fever. 3. R #8's record did not contain a written notices of the bed hold notice. <p>R #9</p> <p>B. Record review of R #9's medical record revealed the following:</p> <ol style="list-style-type: none"> 1. On 12/09/24, R #9 was sent to the hospital for abnormal lab results. 2. R #9's record did not contain a written notice of the bed hold notice. <p>R #11</p> <p>C. Record review of R #11's medical record revealed the following:</p> <ol style="list-style-type: none"> 1. On 12/22/24, R #11 was sent to the hospital for fall. 2. R #11's record did not contain a written notice of the bed hold notice. <p>R #13</p> <p>D. Record review of R #13's medical record revealed the following:</p> <ol style="list-style-type: none"> 1. On 09/14/24, R #13 was sent to the hospital for a change in mental status. 2. R #13's record did not contain a written notice of the bed hold notice. <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 325091	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/28/2025
NAME OF PROVIDER OR SUPPLIER Silver City Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 3514 Fowler Ave Silver City, NM 88061	
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 0625</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>E. On 01/08/25 at 2:55 PM, during an interview, the DON confirmed that she did not see any bed holds for R #8, R #9, R #11, and R #13. The DON did not remember when the bed hold should be provided to the resident.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 325091	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/28/2025
NAME OF PROVIDER OR SUPPLIER Silver City Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 3514 Fowler Ave Silver City, NM 88061	
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 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41755</p> <p>Based on record review and interview, the facility failed to ensure care plans were reviewed and revised for 3 (R #1, R #14 and R #17) of 4 (R #1, R #2, R #14, and R #17) residents reviewed for care plans when they failed to revise the care plan with the most current resident information. This deficient practice could likely result in the care plan not being updated with the most current resident conditions and appropriate interventions, staff being unaware of changes in care provided, and residents not receiving the care related to changes in their health status or healthcare decisions. The findings are:</p> <p>R #1</p> <p>A. Record review of R #1's Admission Record (no date) revealed the following:</p> <ol style="list-style-type: none"> 1. R #1 was admitted to the facility on [DATE]. 2. R #1 had a diagnosis of need for assistance with personal care (providing or assisting in performing daily living tasks and maintaining personal hygiene). <p>B. On 01/22/25 at 7:29 PM, during an interview, CNA #1 stated that R #1 sometimes refuses her showers.</p> <p>C. Record review of R #1's care plan revised on 12/17/24 revealed:</p> <ol style="list-style-type: none"> 1. R #1 had a history of refusing showers. 2. R #1's care plan did not include any interventions (actions taken by facility staff) on how staff is to assist or encourage R #1 when she refuses to shower. <p>R #14</p> <p>D. Record review of R #14's Admission Record revealed R #14 was admitted into the facility on [DATE]. R #14 is diagnosed with type 2 diabetes mellitus without complications.</p> <p>E. Record review of R #14's progress note dated 01/10/25 revealed R #14 continued to refuse blood glucose checks and insulin. R #14 stated I'm not diabetic, the hospital said so.</p> <p>F. Record review of R #14's care plan dated 09/17/24, revealed the care plan did not contain any documentation of R #14 being noncompliant with her insulin. There are no interventions for R #14's refusals documented.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 325091	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/28/2025
NAME OF PROVIDER OR SUPPLIER Silver City Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 3514 Fowler Ave Silver City, NM 88061	
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 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>G. On 01/10/25 at 11:54 AM, during an interview, the DON said she was aware that R #14 is refusing blood glucose checks and insulin. The DON said R #14 believes she has been cured of diabetes. The DON confirmed R#14's noncompliance was not care planned and that there were no interventions for her noncompliance. The DON said R #14's care plan should document that she is refusing insulin and what should be done when R #14 refuses.</p> <p>R #17</p> <p>H. Record review of R #17's Admission Record (no date) revealed the following:</p> <ol style="list-style-type: none"> 1. R #17 was admitted into the facility on [DATE]. 2. R #1 had a diagnosis of need for assistance with personal care. <p>I. On 01/22/25 at 2:22 PM, during an interview, NA #3 said R #17 does not like having his teeth brushed and refuses sometimes.</p> <p>J. Record review of R #17's care plan dated 10/20/24, revealed the care plan did not contain any documentation of R #17 refusing assistance and any interventions on how staff will assist or encourage R #17 when he refuses having his teeth brushed.</p> <p>K. On 01/22/25 at 3:11 PM, during an interview, the DON confirmed staff did not document that R #17 was not compliant with brushing his teeth on his care plan. The DON said that resident's refusals should be documented and that interventions should be care planned.</p> <p>47510</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 325091	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/28/2025
NAME OF PROVIDER OR SUPPLIER Silver City Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 3514 Fowler Ave Silver City, NM 88061	
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 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41755</p> <p>Based on record review, observation, and interview, the facility failed to provide activities of daily living (ADL; activities related to personal care such as bathing, showering, dressing, walking, toileting, and eating) assistance for oral care, baths and showers for 3 (R #1, R #2, and R #17) of 3 (R #1, R #2, and R #17) residents reviewed for ADL care. This deficient practice is likely to affect the dignity and health of the residents. The findings are:</p> <p>R#1</p> <p>A. Record review of R #1's admission record revealed R #1 was admitted into the facility on [DATE].</p> <p>B. Record review of R #1's MDS Quarterly Minimum Data Set (a federally mandated assessment instrument completed by facility staff) dated 12/13/24 indicated R #1 required substantial/maximal assistance (staff lifts or holds trunk or limbs and provides more than half the effort) for showers.</p> <p>C. Record review of the facility's shower schedule revealed R #1 was scheduled for showers on Tuesdays and Fridays on the night shift.</p> <p>D. On 01/22/25 at 11:35 am, during an interview with R #1's family member (FM), she stated she visited R #1 on 12/17/24 (Tuesday) and R #1 was supposed to be showered that day, but she was not showered. R #1's FM stated she was told R #1 would be showered on 12/18/24. FM returned on 12/18/24 and R #1 was not assisted with a bath or shower on that day either.</p> <p>E. Record review of R #1's documentation survey report (ADL tracking form on electronic health record-EHR) dated 12/01/24 through 12/31/24 revealed:</p> <ol style="list-style-type: none"> 1. R #1 was offered/given four (4) baths/showers out of nine (9) opportunities. 2. R #1 did not receive a shower from 12/01/24 until 12/13/24. 3. On 12/17/24 facility staff documented R #1's shower as not applicable. 4. Facility staff did not document why R #1 did not receive a shower on 12/18/24. <p>F. Record review of R #1's documentation survey report dated 01/01/25 through 01/31/25 revealed R #1 was offered/given four (4) baths/showers out of six (6) opportunities.</p> <p>G. On 01/22/25 at 7:29 PM, during an interview, CNA #1 stated R #1 sometimes refuses her shower. CNA #1 stated R #1 was not offered another shower until her next scheduled shower day, but if she asks for a shower in between shower days then the CNA's will try to shower her.</p> <p>R#2</p> <p>H. Record review of R #2's admission record revealed R #2 was admitted into the facility on [DATE].</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 325091	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/28/2025
NAME OF PROVIDER OR SUPPLIER Silver City Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 3514 Fowler Ave Silver City, NM 88061	
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 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>I. Record review of R #2's MDS Quarterly Minimum Data Set, dated dated dated [DATE] indicated R #2 was dependent (staff does all the effort to complete the task) on staff assistance for showers.</p> <p>J. Record review of the facility's shower schedule revealed R #2 was scheduled for showers on Mondays and Thursdays on the night shift.</p> <p>K. Record review of R #2's documentation survey report dated 12/01/24 through 12/31/24 revealed R #2 was offered/given three (3) baths/showers out of nine (9) opportunities.</p> <p>L. Record review of R #2's documentation survey report dated 01/01/25 through 01/31/25 revealed R #1 was offered/given four (4) baths/showers out of six (6) opportunities.</p> <p>M. On 01/22/25 at 7:20 PM, during an interview, CNA #1 stated R #2 was cooperative with her showers and does not refuse. CNA #1 did not say why R #2 was not being showered.</p> <p>R #17</p> <p>N. Record review of R #2's admission record revealed R #17 was admitted into the facility on [DATE].</p> <p>O. Record review of R #17's MDS Quarterly Minimum Data Set, dated dated dated [DATE] indicated R #17 was dependent on staff assistance for showers.</p> <p>P. Record review of the facility's shower schedule revealed R #17 was scheduled for showers on Wednesdays and Saturdays on the day shift.</p> <p>Q. Record review of R #17's documentation survey report dated 12/01/24 through 12/31/24 revealed R #17 was offered/given one (1) baths/showers out of nine (9) opportunities.</p> <p>R. Record review of R #17's documentation survey report dated 01/01/25 through 01/31/25 revealed R #17 was offered/given two (2) baths/showers out of six (6) opportunities.</p> <p>S. On 01/22/25 at 4:13 PM, during an interview, the DON confirmed that documentation for R #17 received only one (1) bath/shower for the month of December 2024. The DON confirmed R #17's documentation showed R #17 received two (2) bath/showers for the month of January 2025. The DON said R #17 should get two (2) bath/showers a week according to the schedule. The DON said R #17 refuses showers.</p> <p>T. On 01/22/25 at 2:00 PM, during an observation of R #17 and interview, R #17's breath smelled horrible. R #17 was shaved and his hair was cut short. R #17 said staff does not brush his teeth and he is not able to brush his own teeth. R #17 said he does get showers.</p> <p>U. Record review of R #17's documentation survey report dated 12/01/24 through 12/31/24 for mouth care-cleaning of teeth/dentures/mouth revealed the following:</p> <ol style="list-style-type: none"> 1. R #17's teeth were brushed two (2) times out of the 31 opportunities on the day shift. 2. R #17's teeth were brushed 25 times out of the 31 opportunities on the night shift. <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 325091	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/28/2025
NAME OF PROVIDER OR SUPPLIER Silver City Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 3514 Fowler Ave Silver City, NM 88061	
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 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>V. Record review of R #17's documentation survey report dated 01/01/25 through 12/31/25 for mouth care-cleaning of teeth/dentures/mouth revealed the following:</p> <ol style="list-style-type: none"> 1. R #17's teeth were brushed four (4) times out of the 31 opportunities on the day shift. 2. R #17's teeth were brushed 10 times out of the 31 opportunities on the night shift. <p>W. On 01/22/25 at 2:22 PM, during an interview, NA #3 said she brushes R #17's teeth for him when he asks. NA #3 said R #17 does not like his teeth to be brushed.</p> <p>X. On 01/22/25 at 3:11 PM, during an interview, the DON said R #17 should get his teeth brushed two times a day. The DON confirmed the documentation revealed R #17 was not getting his teeth brushed regularly in the mornings and the night shift was more consistent at documenting that his teeth are being brushed.</p> <p>47510</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 325091	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/28/2025
NAME OF PROVIDER OR SUPPLIER Silver City Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 3514 Fowler Ave Silver City, NM 88061	
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 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41755</p> <p>Based on record review and interview, the facility failed to ensure that facility staff followed physician's order for 2 (R #1 and R #13) of 5 (R #1, R #2, R #8, R #11 and R #13) residents reviewed for quality of care. Failure to follow physician orders could likely lead to facility staff and physician being unaware of changes in resident condition and could likely lead to worsening of resident's condition. The findings are:</p> <p>R #1</p> <p>A. Record review of R #1's admission record (no date) revealed R #1 was admitted to the facility on [DATE].</p> <p>B. Record review of R #1's physician orders revealed an order date 08/30/2024: Weight every day shift every seven (7) days, scheduled every Saturday for monitoring.</p> <p>C. Record review of R #1's Nutritional assessment dated [DATE] revealed the following:</p> <ol style="list-style-type: none"> 1. Weight gain would be beneficial given very low body mass index (BMI;a tool that healthcare providers use to estimate the amount of body fat by using height and weight measurements and helps assess risk factors for certain health conditions). 2. R #1 was underweight for age. R #1 weighed 83.2 pounds. <p>D. Record review of R #1's weights log dated 01/22/25 revealed the following:</p> <ol style="list-style-type: none"> 1. October 2024, R #1 was only weighed twice out of four (4) opportunities. 2. November 2024, R #1 was only weighed twice out of five (5) opportunities. 3. December 2024, R #1 was only weighed once out of four (4) opportunities. 4. January 2025, R #1 was only weighed once out of three (3) opportunities. <p>E. On 01/23/25 at 12:16 PM, an interview, LPN #1 confirmed R #1 did have a physician's order in place to be weighed weekly and staff did not weigh R #1 weekly as ordered.</p> <p>R #13</p> <p>F. Record review of R #13's admission record, no date, revealed R #13 was admitted to the facility on [DATE].</p> <p>G. Record review of the R #13's order summary, dated 02/29/24, revealed the following:</p> <ol style="list-style-type: none"> 1. Humalog (insulin medication used to help lower blood sugar), inject three (3) units subcutaneously (beneath the skin) before meals, hold if blood glucose is less than 100. <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 325091	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/28/2025
NAME OF PROVIDER OR SUPPLIER Silver City Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 3514 Fowler Ave Silver City, NM 88061	
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 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>2. Lantus (long acting insulin) inject 15 units subcutaneously in the morning. Call physician prior to administration if blood glucose is less than 90.</p> <p>H. Record review of R #13's MAR dated 09/01/24 through 09/30/24 for Humalog revealed the following:</p> <ol style="list-style-type: none"> 1. On 09/09/24 R #13's blood glucose was not documented. 2. On 09/01/24 R #13's blood glucose was not documented. 3. On 09/01/24 R #13's blood glucose was not documented. 4. On 09/02/24 before breakfast, R #13's blood glucose was 104 and humalog was not given. 5. On 09/02/24 before lunch, R #13's blood glucose was 129 and humalog was not given 6. On 09/04/24 before lunch, R #13's blood glucose was 120 and was humalog was not given 7. On 09/04/24 before dinner, R #13's blood glucose was 134 and humalog was was not given. 8. On 09/05/24 before breakfast, R #13's blood glucose was 101 and humalog was not given. 9. On 09/05/24 before lunch, R #13's blood glucose was 101 and humalog was not given. 10. On 09/05/24 before dinner, R #13's blood glucose was 188 and humalog was not given. 11. On 09/09/24 before lunch, R #13's blood glucose was 145 and humalog was not given. 12. On 09/13/24 before breakfast, R #13's blood glucose was 121 and humalog was not given. 13. On 09/05/24 before dinner, R #13's blood glucose was 134 and humalog was not given. <p>what was the reason for holding the medication?</p> <p>I. Record review of R #13's MAR dated 09/01/24 through 09/30/24 for Lantus revealed the following:</p> <ol style="list-style-type: none"> 1. On 09/07/24 R #13's blood glucose was 78, lantus was held. 2. On 09/09/24 R #13's blood glucose was 98 and lantus was not given. 3. On 09/10/24 R #13's blood glucose was 84, lantus was held. 4. The MAR did not contain any documentation that the physician was notified when the insulin was not given. <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 325091	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/28/2025
NAME OF PROVIDER OR SUPPLIER Silver City Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 3514 Fowler Ave Silver City, NM 88061	
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 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>J. On 01/10/25 at 11:55 AM, during an interview, the DON stated R #13 was not always compliant with blood glucose checks and taking her insulin. The DON confirmed that the physician was not notified when R #13's insulin was being held or when R #13 was noncompliant. The DON said that if R #13 is refusing insulin, after three attempts, the physician should be notified and it should be documented in R #13's medical record that the provider was notified.</p> <p>K. On 01/13/25 at 1:24 PM, during an interview, DR #1 confirmed that if R #13's humalog was being held when her blood glucose levels are above 100 that the order was not being followed. DR #1 confirmed R #16's lantus was being held when her blood glucose was above 90, the order was not being followed. DR #1 said he does not recall being notified when R #13's insulin was being held. DR #1 said that he does not know why the orders were not being followed.</p> <p>47510</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 325091	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/28/2025
NAME OF PROVIDER OR SUPPLIER Silver City Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 3514 Fowler Ave Silver City, NM 88061	
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 0835</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Administer the facility in a manner that enables it to use its resources effectively and efficiently.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47510</p> <p>Based on record review and interview, the facility failed to have an effective administration that maintained the highest practicable well-being of residents for 1 (R #16) of 3 (R #1, R #16, and R #17) residents reviewed when the administration failed to recognize the mistreatment, dehumanization (the process of depriving a person or group of positive human qualities) and disrespect to R #16 when she was used by staff to prank another staff member after she was deceased . If the administration is unable to adequately identifying the mistreatment of residents, even of deceased residents still under the care of the facility and establish a standard of practice by implementing adequate corrective action when failures are identified, then residents remain at risk of serious adverse outcomes. The findings are:</p> <p>Cross reference findings from F550 and F610</p> <p>A. On [DATE] at 4:36 PM, during an interview, NA #1 stated she got to work on [DATE] at 6:00 am. NA #1 said that she noticed R #16's door was closed, and the door being closed was unusual. NA #1 said that at 6:30 AM, RN #1 asked her to take R #16's vital signs. NA #1 stated when she went into R #16's room, the room was cold. NA #1 said R #16 would usually respond to her right away when entering the room. NA #1 said R #16's dentures did not seem to be sitting right in her mouth. NA #1 further stated R #16 did not respond to her, she nudged R #16 and noticed at that time she was cold. NA #1 stated she realized R #16 had passed, so she left the room to let staff know and RN #1 was standing outside the room laughing. NA #1 stated RN #1 said it was a cruel rookie joke that he was playing and RN #1 told NA #1 not to say anything because he wanted to play the joke on another staff. NA #1 said that she was so distraught that emergency medical services had to be called to check her out because she was having a panic attack.</p> <p>B. Record review of a written statement dated [DATE], from CMA #1 revealed there was another staff member that was going to be asked to take vital signs on the deceased resident as a friendly joke but that staff member did not report to work. CMA #1 wrote NA #1 was the one sent into the room [to be pranked].</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 325091	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/28/2025
NAME OF PROVIDER OR SUPPLIER Silver City Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 3514 Fowler Ave Silver City, NM 88061	
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 0835</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>C. On [DATE] at 12:07 PM, during an interview, the Administrator said she is the Abuse Coordinator and she is the one that took the lead on the investigation of R #16 not the DON. The Administrator said R #16 passed away during the night on [DATE] at 10:56 am, and she was not at the facility. The Administrator said the morning after R #16 passed away, she was told that RN #1 told NA #1 to go check vital signs on R #16. The Administrator said she was not told checking the vitals was a joke that was being played on NA #1. The Administrator said RN #1 used the passing of R #16 as a teaching opportunity to teach NA #1 what to do when a resident passes. The Administrator said when she arrived to the facility on [DATE], NA #1 was passing trays. The Administrator said NA #1 became upset and started breathing heavy and NA #1 said she had a rough morning. The Administrator said they called an ambulance to come check NA #1. The Administrator said NA #1 ended up going home for the day. The Administrator said she did not submit a report to the state because she thought it was a staff thing. The Administrator stated she received an email from [Name of NA #1's] family member informing her that NA #1 was sent to R #16's room after she had passed away, was a joke and only after she received the email did she initiate an investigation [[DATE]]. The Administrator said NA #1 was not interviewed because she did not return the phone calls. The Administrator said RN #1 was not suspended because he was already scheduled to be off the days following the incident on [DATE] (RN #1 was still working in the facility until [DATE]. See plan of removal.) The Administrator said RN #1 received a written reprimand and was told not to do anything like that again without running it by herself or the DON. The Administrator said that RN #1 should not have told NA #1 to do vitals on a dead resident because NA #1 was young and could not handle it. The Administrator confirmed that the incident involving R #16 was not reported to the state as a staff to resident incident because she did not understand how this incident would have affected R #16 because she was already deceased . The Administrator confirmed that there was not any education or correction provided for RN #1 or other staff regarding respecting deceased residents. The Administrator never acknowledged that the prank was inappropriate.</p> <p>D. Record review of a written statement, no date (the Administrator did not date her statement), from the Administrator [detailing the events as she recalled them. The statement was made as part of the facility's investigation.], revealed NA #1 told her a joke had been played on her when RN #1 sent her into the resident's room do vitals on a dead lady.</p> <p>E. Record review of the facility's investigation report dated [DATE], revealed no written statement from the DON. The Administrator did not document DON's involvement in the investigation or the incident or as it related to the oversight of RN #1 and other nursing staff involved.</p> <p>F. Record review of the individual performance improvement plan for RN #1 dated [DATE], revealed RN #1 was given a written reprimand for sending NA #1 to get vitals on a deceased resident [due to NA #1 being inexperienced]. The Administrator did not document any reprimand related to the mistreatment of a deceased resident.</p> <p>G. On [DATE], three attempts were made to contact RN #1 for an interview. RN #1 did not answer, voicemails were left, and RN #1 did not return any of the calls.</p> <p>The above findings resulted in an Immediate Jeopardy that was called on [DATE] at 4:55 PM</p> <p>The facility submitted a final plan of removal on [DATE] at 4:45 PM and the IJ was lifted, implementation was verified onsite. Training was reviewed, staff were interviewed and policy verified. Scope and severity was reduced to level 2, D.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 325091	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/28/2025
NAME OF PROVIDER OR SUPPLIER Silver City Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 3514 Fowler Ave Silver City, NM 88061	
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 0835</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Plan of Removal .The following identification/corrections will be completed by [DATE]:</p> <p>-The Administrator and DON were re-educated on [DATE] - [DATE] on numerous calls by the Market level staff, including the Market President special projects, Market Operation Advisor, Market Clinical Advisor, on the policy and procedures on Resident abuse and neglect with emphasis on dignity, respect and mistreatment, allegations of abuse being identified, immediate intervention put in place to prevent reoccurrence, immediate reporting to the appropriate state agencies and thorough investigation and resident rights.</p> <p>-The Market Operations Advisor and Market Clinical Advisor will have oversight of the Administration of the facility effective immediately. Current Administrator and Director of Nursing to be placed on administrative leave pending additional retraining by New Mexico Market level and facility National legal/risk staff on thorough investigations, federal definitions of abuse/neglect and facility policy. All aspects of all investigations will be reviewed by the Market Ops Advisor and/or Market Clinical Advisor, and reviewed to ensure the investigation is complete and thorough.</p> <p>-The Senior Operation resource lead and the Market Clinical resource lead will monitor and run the operational and clinical affairs of the facility to ensure quality care is provided to the residents at the facility. The Senior Operation resource lead also will assume the role of the facility abuse coordinator and will receive reports on all alleged abuse/neglect concerns.</p> <p>-A full investigative audit occurred within the facility from [DATE] through [DATE] to ensure no other current residents have been mistreated or have felt they were treated undignified. Residents that are alert and able to answer questions were asked if they felt they have been treated undignified and for the residents not able to answer, their families/POA's (Power of Attorney the authority to act for another person in specified or all legal or financial matters) /guardians were called and asked the same question. and if any further mistreatment or undignified treatment comes forward, the facility will remove any resident from the situation, and proper monitoring and interventions will be initiated immediately upon notification. No new allegations of abuse have been provided.</p> <p>-If any staff are identified in an allegation of abuse, neglect, undignified behavior or mistreatment, the staff member will be removed from the situation to ensure resident safety and dignity, and the staff member will immediately be placed on administrative leave pending the investigation completion.</p> <p>-On [DATE] the identified RN of concern was placed on administrative leave pending the investigation. The RN's last scheduled day of work was [DATE].</p>		