STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	325092	A. Building B. Wing	12/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
New Mexico State Veterans Home	992 South Broadway Truth OR Consequence, NM 87901

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. 41755 Based on interview and record review, the facility failed to promote resident self-determination (the ability to make your own choices and decisions without being controlled by others) for 1 (R #18) of 3 (R #18, R #69 and R #256) residents reviewed for choices when staff did not allow the resident to go out into the community on their own. If the facility is not honoring resident's choices, then residents are likely to feel a loss of independence and self-worth leading to feelings of frustration and depression. The findings are: A. Record review of R #18's admission Minimum Data Set (MDS; a standardized, comprehensive assessment of an adult's functional, medical, psychosocial, and cognitive status) assessment, dated 09/06/24, revealed: 1. Brief Interview for Mental Status (BIMS; screening tool used to identify a resident's current cognitive function) evaluation score of 15, cognitively intact. B. Record review of R #18's progress notes revealed the following: 1. Social services note, dated 09/04/24, Talk (sic) to [name of R #18] regarding him leaving the facility. He say he will continue leaving the facility because he is not a prisoner . 2. Social services note dated 09/09/24: I and [name of other social services staff] talked with [name of R #18] about leaving the [name of facility] campus. We tried to get across to him that he cannot leave the campus unauthorized. He insists on leaving whenever he wants to. We talked to him about the safety issues, and he still said that he was going to go out, especially on Sundays for church. We even told him that if he wants to go across the street to [name of local store], that we would assign someone to him to keep him safe. He insisted that he would be safe and that he did not need to be assisted. He said no to our requests several times during our meeting. 3. Nursing progress noted dated 11/02/24: Resident educated on current policy for leaving the [name of facility] alone. Resident reports having a contract stating that he has the right to go downtown by himself. Resident also states, 'Until I see this in writing, it is my right to go off the facility by myself.' (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4. Nursing progress noted dated 11/04/24: Called to resident son and left voicemail informing him of resident behavior of leaving campus, asked the son to speak with resident regarding safety risks of leaving campus. 5. Nursing progress noted dated 11/13/24: During morning med (medication) pass, resident asked this writer if it was possible for him to go to [name of local store]. This writer reminded him that, per policy, he would need a member of the staff to go with him. Resident stated that he was not a prisoner and would go if he felt it necessary C. Record review of R #18's Independent Travel Contract, dated 04/29/24, revealed R #18 received approval from the Interdisciplinary Care Team for the privilege of Independent Traveler (can leave the facility without staff assistance). D. On 11/19/24 at 3:54 PM, during an interview, R #18 stated the facility staff told him he could not leave the facility campus on his own. R #18 stated he had a contract to allow him to leave the facility. E. On 12/02/24 at 4:58 PM, during an interview with Social Services #1, she stated none of the residents can leave the facility without staff supervision due to safety concerns.

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. 49313 Based on record review and interview, the facility failed to notify the resident and the resident's representative of a transfer in writing for 1 (R #12) of 1 (R #12) residents sampled for hospitalization s when they failed to: 1. Notify the resident or the resident's representative of the transfers to the hospital in writing and in a language and manner they understand. 2. Ensure the contents of the notice included the following: -The name, phone number, and address (mailing and email) of the Office of the State Long-Term Care Ombudsman on the transfer notification form. -Statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request. 3. Send a written copy of the Transfer Notices to the Ombudsman. These deficient practices could likely result in the resident and/or their representative not knowing the reason for a transfer, and their rights to advocate and make informed decision regarding their healthcare. The findings are: A. On 11/19/24 at 11:04 AM, during an interview with R #12, he stated the following: 1. He was transferred to the hospital, because he had trouble breathing. R #12 was unable to remember the date of the transfer. 2. Staff did not give him transfer paperwork before he was transferred to the hospital or when he returned to the facility. B. Record review of R #12's admission documents, no date, revealed R #12's son was his emergency contact. C. Record review of R #12's progress notes, dated 10/29/24, revealed R #12 was transferred to the hospital on 10/29/24 for abnormal laboratory results and returned the same day. D. Record review of R #12's transfer document, dated 10/29/24, revealed the following: 1. Staff did not document that staff provided a copy of the transfer notice to the resident or their representative. 2. Staff did not document the name, phone number, or address (mailing and email) of the Office of the State Long-Term Care Ombudsman. (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3. Staff did not document a statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request. 4. Staff did not document that staff sent a written copy of the Transfer Notice to the Office of the State Long-Term Care Ombudsman. E. Record review of R #12's progress notes, dated 11/02/24, revealed R #12 was transferred to the hospital on 11/02/24 for hitting his head during a fall, he returned the same day. F. Record review of R #12's transfer form, dated 11/02/24, revealed the following: 1. Staff did not document that staff provided a copy of the transfer notice to the resident or their representative. 2. Staff did not document the name, phone number, or address (mailing and email) of the Office of the State Long-Term Care Ombudsman. 3. Staff did not document a statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request. 4. Staff did not document that staff sent a written copy of the Transfer Notice to the Office of the State Long-Term Care Ombudsman. G. On 12/02/24 at 12:10 PM, during an interview with LPN #16, she stated the following: 1. Nursing staff were expected to complete a transfer assessment prior to sending a resident to the hospital. 2. Staff did not have the resident sign the transfer assessments prior to being sent to the hospital on 10/29/24 and 11/02/24. 3. Staff did not give a copy of the transfer assessments to the resident or their representative. 4. She confirmed that the transfer assessments did not have information on how to contact the Office of the State Long-Term Care Ombudsman. 5. She confirmed that the transfer assessments did not have a statement of the resident's appeal rights. H. On 12/02/24 at 4:54 PM, during an interview with the DON, he stated the following: 1. Staff were expected to document a note in the resident's medical record regarding information about the reason for the transfer to the hospital. (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Staff were not expected to complete a transfer notification prior to sending residents to the hospital or upon return. 3. Staff were not expected to give the resident a transfer notification prior to sending the resident to the hospital or upon return. I. On 12/04/24 at 8:43 AM, during an interview with the Ombudsman, she confirmed that the Office of the State Long-Term Care Ombudsman did not receive any transfer notices from the facility for any residents.

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. 49313 Based on record review and interview, the facility failed to ensure residents and their representatives received a written notice of the bed hold policy which indicated the duration the bed would be held for 1 (R #12) of 1 (R #12) 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: A. On 11/19/24 at 11:04 AM, during an interview with R #12, he stated the following: 1. He was transferred to the hospital because he was having trouble breathing. R #12 was unable to remember the date of the transfer. 2. Staff did not give him a bed hold policy notification before he was transferred to the hospital or when he returned to the facility. B. Record review of R #12's admission documents, no date, revealed R #12's son was his emergency contact. C. Record review of R #12's progress note, dated 10/29/24, revealed R #12 was transferred to the hospital on 10/29/24 for abnormal laboratory results. D. Record review of R #12's Notification of Bed Hold, dated 10/29/24, revealed the following: 1. Staff did not document how many days a bed would be held for the resident (the form does not have a space to provide this information). 2. Staff documented unable to sign on the line titled resident name. 3. Staff did not document that staff provided the written Notification of Bed Hold to the resident. 4. Staff did not document that staff provided the written Bed Hold Notification form to the resident's representative. E. Record review of R #12's progress note, dated 11/02/24, revealed R #12 was transferred to the hospital on 11/02/24 for hitting his head during a fall. F. Record review of R #12's Notification of Bed Hold, dated 11/11/24, revealed the following: 1. Staff did not document how many days a bed would be held for the resident. 2. The form was blank on the resident signature line. (continued on next page)

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3. Staff did not document that staff provided the written Notification of Bed Hold to the resident. 4. Staff did not document that staff provided the written Bed Hold Notification form to the resident's representative. G. Record review of the facility's Bed Hold Policy, no date, revealed the policy did not indicate that residents with specific payment sources had an unlimited number of bed hold days. H. Record review of the facility's Bed-Hold Authorization & Agreement form, no date, revealed the following: 1. The Bed-Hold Authorization & Agreement form and the Notification of Bed Hold forms contained different information. 2. The Bed-Hold Authorization & Agreement form indicated Every Veteran and/or Non-Veteran resident are annually granted 12 hospital bed days free of charge . 3. The Notification of Bed Hold form did not have any information specific to residents with the Veterans Administration payment source . 4. The Bed-Hold Authorization & Agreement form and the Notification of Bed Hold forms did not have a place to document how many bed hold days the resident had remaining. I. On 12/02/24 at 12:10 PM, during an interview, LPN #16 stated the following: 1. Nurses completed a Bed-Hold Authorization & Agreement form when a resident transferred to the hospital. 2. If the resident was alert at the time of transfer, then the nurses discuss the Bed Hold Policy with them. The nursed will have them sign the Bed-Hold Authorization & Agreement form. 3. If the resident is not able to sign the Bed-Hold Authorization & Agreement form, the nurse will complete a verbal bed hold with the resident or the resident representative. 4. The Bed Hold Policy Notification Policy was sent with the resident at the time of the transfer to the hospital. J. On 12/02/24 at 3:48 PM, during an interview with the DON, the following was confirmed: 1. The nurses were expected to complete and give residents a copy of the Bed Hold Policy. 2. The nurses were expected to complete the Notification of Bed Hold form when a resident was transferred to the hospital. 3. The Bed-Hold Authorization & Agreement form was an old form, and staff should not be giving that form to residents at the time of transfer [See finding H, indicating that some staff are providing this form to residents at the time of transfer]. (continued on next page)

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	4. He stated R #12 had unlimited number of bed hold days due R #12's payment source being the Veterans Administration 5. R #12's Notification of Bed Hold form, dated 10/29/24, did not include that due to R #12's payment source, he had an unlimited number of bed hold days. 6. R #12's Notification of Bed Hold form, dated 11/11/24, did not include that due to R #12's payment source, he had an unlimited number of bed hold days.

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F 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Encode each resident's assessment data and transmit these data to the State within 7 days of assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41755 Based on record review the facility failed to ensure the annual Minimum Data Set assessment (MDS; a standardized, comprehensive assessment of an adult's functional, medical, psychosocial, and cognitive status) was finalized (transmitted and accepted) within 7 days for 1 (R #25) of 4 (R #18, R #25, R #51 and R #87) residents reviewed for MDS assessments. If MDS assessments are not finalized in a timely manner, it could likely lead to staff being unaware of resident's current status and needs. The findings are: A. Record review of R #25's admission record (no date) revealed an admitted [DATE]. B. Record review of R #25's annual MDS assessment, dated 10/10/24, revealed the following: 1. The Assessment Reference Date (ARD; specific end point for the observation and assessment period in the MDS assessment process) was 10/10/24. 2. The MDS/RN Coordinator did not sign off on the annual assessment until 11/20/24. C. Record review of R #25's electronic medical record indicated the 10/10/24 annual assessment was export ready (assessment ready for electronic transmission) on 11/21/24.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41755 Based on interview and record review, the facility failed to ensure the Minimum Data Set Assessment (MDS; a standardized, comprehensive assessment of an adult's functional, medical, psychosocial, and cognitive status) was accurate for 3 (R #18, R #69 and R #256) of 6 (R #18, R #51, R #69, R #76, R #87, and R #256) residents reviewed for accurate MDS assessments. These deficient practices could likely result in the facility not having an accurate assessment of the resident's needs. The findings are: R#18 A. On 11/19/24 at 4:07 PM, during an interview, R #18 stated he had pain and a burning feeling to his feet daily. B. Record review of R #18's admission record revealed the following: 1. admitted [DATE]. 2. Diagnoses included carpal tunnel syndrome of unspecified upper limb (pain, numbness, tingling caused by pressure on the median nerve in of either wrist), unilateral primary osteoarthritis of unspecified knee (pain, swelling, and tenderness caused by wear and tear on a joint, that primarily affects one side of the body), and pain in unspecified (either left or right) shoulder. C. Record review of R #18's physician orders revealed the following: 1. Order date 08/26/24, gabapentin (medication used to treat nerve pain), 800 mg. Give one tablet by mouth one time a day in the evening for pain. 2. Order date 08/27/24, gabapentin, 800 mg. Give one tablet by mouth in the morning and one tablet by mouth at midday. D. Record review of R #18's admission MDS assessment, dated 09/06/24, revealed the following: 1. Staff did not conduct a pain assessment interview, because the resident was rarely/never understood. 2. Brief Interview for Mental Status (BIMS; screening tool used to identify a resident's current cognitive function) evaluation score of 15, cognitively intact. E. On 12/02/24 at 1:20 PM, during an interview LPN #1 stated R #18 did not have any problems being understood or communicating, and he could give a verbal response regarding his pain levels. R #69 F. Record review of R #69's quarterly MDS assessment, dated 10/06/24, revealed staff documented the resident took an anticoagulant. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	G. Record review of R #69's physician's orders revealed the following: 1. The record did not contain an order for anticoagulant medication. H. On 12/02/24 at 3:12 PM, during an interview the DON confirmed R #69 did not take anticoagulant medication. R#256 I. On 11/19/24 at 1:55 PM, during an interview, R #256 stated he had pain all the time. J. Record review of R #256's admission record, no date, revealed the following: 1. admitted [DATE]. 2. Diagnoses included low back pain (pain or ache in the lower region of the back, varying in intensity) and unspecified inflammatory spondylopathy (arthritis-related conditions that affect the spine and the connective tissues of bones.) K. Record review of R #256's admission MDS assessment, dated 11/17/24, revealed the following: 1. Staff did not conduct a pain assessment interview, because the resident was rarely/never understood. 2. BIMS score of 10, moderate cognitive impairment. L. On 12/02/24 at 1:13 PM, during an interview LPN #1 stated R #256 did not have any problems being understood or communicating, and he could give a verbal response regarding his pain levels.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41755 Based on observation, record review and interview, the facility failed to ensure care plan requirements were met for 11 (R #4, R #6, R #18, R #48, R #49, R #51, R #57, R #62, R #78, R #87 and R #256) of 14 (R #4, R #6, R #18, R #48, R #49, R #51, R #57, R #62, R #69, R #73, R #76, R #78, R #87 and R #256) residents reviewed for care plans when they failed to: 1. Have the required Interdisciplinary Team (IDT, team members from different disciplines working collaboratively, with a common purpose, to set goals, make decisions and share resources and responsibilities) members participate in the care plan meeting for R #4, R #6, R #18, R #51, R #57, R #78, and R #87. 2. Ensure the care plan meeting was held within seven days of completion of the admission Minimum Data Set Assessment (MDS; a standardized, comprehensive assessment of an adult's functional, medical, psychosocial, and cognitive status) for R #256. 3. Revise the care plan with the most current resident information for R #48, R #49, R #51, and R #62. These deficient practices 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: IDT Team R #4 A. Record review of R #4's care plan meeting note, dated 11/14/24, revealed the staff present for the meeting were RN/MDS Coordinator, Social Services, and Activities. R #6 B. Record review of R #6's care plan meeting note, dated 11/07/24, revealed the staff present for the meeting were RN/MDS Coordinator, Certified Dietary Manager/Certified Food Protection Professional (CDM/CFPP)/Dietary, and Social Services. R #18 C. Record review of R #18's care plan meeting note, dated 09/19/24, revealed the staff present for the meeting were RN/MDS Coordinator, social services staff, activities staff, dietary staff, and guide (lead CNA for R #18's home). R #51 (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	D. Record review of R #51's care plan meeting note, dated 09/05/24, revealed the staff present for the meeting were RN/MDS Coordinator, social services staff, activities staff, and dietary staff. R #57 E. Record review of R #57's care plan meeting note, dated 09/12/24, revealed the staff present for the meeting were RN/MDS Coordinator, CDM/CFPP/Dietary, and social services. R #78 F. Record review of R #78's care plan meeting note, dated 10/17/24, revealed the staff present for the meeting were RN/MDS Coordinator, CDM/CFPP/Dietary, and Social Services. R #87 G. Record review of R #87's care plan meeting note, dated 10/24/24, revealed the staff present for the meeting were RN/MDS coordinator, dietary staff, activities, and social services staff. H. On 11/20/24 at 3:15 pm, during an interview, the MDS Coordinator said she invited Dietary, Social Services (SS), and Activities to the care plan meetings. The MDS Coordinator said the IDT team consisted of dietary, SS, MDS for nursing, and activities. The MDS Coordinator said she called the DON or ADON if needed. The MDS Coordinator said she got the most current resident information from the progress notes and sometimes talked to the guides if they had questions [each home had a person designated at the home to oversee and coordinate care at the house.] The MDS Coordinator said if she had questions, then she will ask the nurses or staff. The MDS Coordinator said the physician or medical director was not invited to the meetings. Care Plan timing R #256 I. Review of R #256's medical record revealed the following: 1. R #256 was readmitted to the facility on [DATE]. 2. R #256's admission MDS was completed on 11/20/24. J. Record review of R #256's progress notes revealed the facility did not have a care plan meeting for the resident as of 12/02/24. Care Plan Revisions R #48 K. On 11/19/24 at 10:52 AM, an observation and interview with R #48 revealed the following: 1. R #48's legs were swollen. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. R #48 did not wear any compression stockings. 3. R #48 said he had order for medication for the swelling in his legs. L. Record review of R #48's physician's orders revealed the following: 1. An order dated 06/03/24 to 06/06/24, for furosemide [medication used to treat fluid retention (edema) and swelling caused by congestive heart failure, liver disease, kidney disease, and other medical conditions,] 40 mg once a day for edema to both legs. 2. An order dated 06/06/24, for furosemide, 20 mg once a day for edema to both legs. 3. An order dated 07/22/24 to 08/22/24, for furosemide, 40 mg once a day for 30 days for acute kidney failure. 4. An order dated 08/23/24 to 08/28/24, for furosemide, 40 mg once a day for five days for edema related to acute kidney failure. 5. An order dated 09/23/24 to 09/26/24, for furosemide, 40 mg twice a day for edema in both legs. 6. An order dated 09/26/24, for furosemide, 40 mg once a day for edema in both legs. 7. An order dated 10/15/24 to 10/17/24, for furosemide, 40 mg twice a day for three days for edema in both legs. 8. An order dated 11/06/24, for compression stockings (tighter than average socks. They gently squeeze your legs to help your blood flow back toward your heart) one time a day. 9. An order dated 11/08/24 to 11/18/24, for metolazone (medication used to treat fluid retention and swelling that is caused by congestive heart failure, kidney disease, or other medical conditions,) 5 mg in the morning for 10 days for edema. M. Record review of R #48's care plan, revised 09/26/24, revealed the following: 1. R #48's care plan did not include he had edema. 2. R #48's care plan did not include the interventions in place to alleviate his edema. N. On 12/02/24 at 12:23 PM, an interview with LPN #17 revealed the following: 1. R #48 had edema in both legs. 2. R #48's edema worsens when he sats in his wheelchair. Staff encourage him to elevate his feet. 3. R #48 had an order for compression stockings to alleviate edema. 4. R #48 had an order for furosemide for the edema in his legs. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	5. R #48 refused to elevate his legs or to wear his compression stockings. O. On 12/02/24 at 3:40 PM, during an interview with the DON, he confirmed the following: 1. R #48's care plan did not include he had edema or any interventions in place to treat his edema. 2. R #48's care plan should have included R #48 had edema and the interventions in place to treat his edema. R #49 P. On 11/19/24 at 1:43 PM, an interview with R #49's resident representative revealed the following: 1. R #49 fell two times on 09/29/24. 2. After the second fall on 09/29/24, R #49 was sent to the hospital. 3. R #49 fell on ce about two weeks (she did not remember the date.) Q. Record review of R #49's progress note, dated 09/27/24 [date did not match the date R #49's resident representative stated], revealed R #49 fell , and staff did not note any injuries. R. Record review of R #49's progress note, dated 09/28/24, [date did not match the date that R #49's resident representative stated] revealed the following: 1. R #49 had an unwitnessed fall and sat on the floor mat at the foot of his bed. 2. His bed was in the lowest position. 3. R #49 stated that he hit his head and had pain. 4. R #49 was sent to the hospital for evaluation. S. Record review of R #49's progress note, dated 10/02/24, revealed staff found R #49 sitting on the floor in front of his wheelchair, and he did not have any injuries. T. Record review of R #49's progress note, dated 11/06/24, revealed the following: 1. R #49 fell when he tried to get himself out of bed. 2. R #49 did not have any injuries. 3. R #49's floor mat was in place. 4. R #49's bed was in low position. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	U. Record review of R #49's physician order, dated 10/28/24, revealed an order for R #49's bed to be in the lowest position and a fall mat to be in place when R #49 was in bed. V. Record review of R #49's care plan, dated 10/01/24, revealed the following: 1. R #49 was at risk for falls. 2. Staff were to evaluate R #49's fall risk. 3. R #49 was to have a fall mat in place by his bed. 4. Staff were to initiate fall risk precautions [Did not specify what the fall risk precautions were.] 5. R #49's care plan was not revised to include that R #49 had actual falls. 6. R #49's care plan was not revised to include the order for R #49's bed to be in the lowest position when in bed. W. On 12/02/24 at 10:08 AM, an interview with CNA #16 revealed the following: 1. R #49 was at risk for falls. 2. R #49 had a fall mat next to his bed. 3. R #49 had bed rails for support. 4. R #49's bed to be in the lowest position. 5. Staff checked on R #49 frequently to ensure he did not fall. 6. Staff tried to keep R #49 up in his chair and busy so he would not fall. X. On 12/02/24 at 10:12 AM, an interview with LPN #16 revealed the following: 1. R #49's was a fall risk. 2. Staff kept R #49 in the common area when he was in his wheelchair. 3. R #49 was restless and required staff to check on him every 30-45 minutes. 4. R #49's bed was supposed to be in the lowest position. 5. R #49 had a fall mat next to his bed. 6. R #49's care plan did not include R #49's actual falls on 09/27/24, 09/28/24, 10/02/24, and 11/06/24. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	7. R #49's care plan did not include the interventions to check on him frequently, keep him in the common area when in his wheelchair, and to keep his bed in the lowest position. Y. On 12/02/24 at 3:22 PM, during an interview with the DON, he confirmed the following: 1. Staff did not document R #49's actual falls on his care plan. 2. Staff did not document on R #49's care plan that his bed should be in the lowest position, that he should be taken to the common area when he is restless, or the frequency that staff should check on R #49. 3. R #49's care plan should have been revised to include that he had actual falls and the interventions identified to prevent him from falling or injuring himself. R #51 Z. Record review of R #51's physician orders revealed the following: 1. Order start date 08/21/24, order discontinue date 09/20/24: Left foot treatment, Hydrofera blue (powerful antibacterial wound dressing) with saline (sterile mixture of salt and water), betadine (topical antiseptic and germicide) painted around wound edges, betadine soaked 4 by (x) 4 (gauze measuring four inches by four inches,) dry 4x4, Kerlix (bandage roll), Ace (elastic bandage) wrapped, placed in Rooke (naturally warming boot used to treat and prevent skin breakdown) boot. 2. Order start date 09/11/24: left heel diabetic ulcer (open sore or wound on the foot of a person with diabetes), cleanse with wound cleanser, pat dry, apply collagen wound gel (wound treatment that promotes new tissue growth) to wound bed, cover with foam dressing (absorbent wound covering.) AA. Record review of R #51's care plan, dated 08/21/24, revealed R #51 had a chronic ulcer to left foot; wound dressing, and left foot treatment to include Hydrofera blue with saline, betadine painted around would edges, betadine soaked 4x4, dry 4x4, Kerlix, Ace wrapped, placed in Rooke boot. BB. On 12/02/24 at 4:21 PM, during an interview, the DON confirmed the wound care order for R #51 changed on September 11, 2024, and staff did not revise the care plan to reflect the current wound care order. R#62 CC. Record review of R #62's admission documents, no date, revealed the following: 1. R #62 was admitted to the facility on [DATE]. 2. R #62 had the following diagnoses: a. Bipolar Disorder (serious mental illness characterized by extreme mood swings, that can include extreme excitement episodes or extreme depressive feelings). b. Depression (mood disorder that causes a persistent feeling of sadness and loss of interest.) (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	c. Dementia (term used to describe a group of symptoms affecting memory, thinking and social abilities.) d. Post-Traumatic Stress Disorder (PTSD, mental health condition that develops following a traumatic event characterized by intrusive thoughts about the incident, recurrent distress/anxiety, flashback, and avoidance of similar situations.) DD. On 11/19/24 at 10:12 AM, during an interview with R #62, he stated the following: 1. The facility has not done anything for his mental health diagnoses or history of trauma. 2. Prior to coming to the facility, he used to receive therapy for his mental health diagnoses. 3. He would benefit from behavioral health services for his mental health diagnoses. EE. Record review of R #62's physician's order, dated 08/14/24, for paroxetine, 20 mg one time a day for depression/anxiety (an emotion characterized by feelings of tension, worried thoughts, and physical changes like increased blood pressure.) FF. Record review of R #62's nursing progress note, dated 09/10/24, revealed the following: 1. R #62 stayed in bed throughout the day shift. 2. R #62 refused lunch and refused to get out of bed. 3. R #62 stated he was giving up. 4. Staff contacted R #62's Power of Attorney (POA, the authority to act for another person in specified or all legal or financial matters) to talk to R #62 since he was feeling alone. 5. R #62's POA was going to speak to family about requesting a psychiatric consultation (a meeting with a psychiatrist to evaluate a patient's mental health and provide a diagnosis and treatment recommendations) for R #62. GG. Record review of R #62's social service progress note, dated 09/11/24, revealed the following: 1. The social worker was notified R #62 was depressed and done with life. 2. R #62 was not motivated and would barely talk to the social worker. 3. R #62 stated he did not believe in God. 4. R #62 stated he wanted to die. HH. Record review of R #62's care plan, multiple dates, revealed the following: (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1. On 06/25/24, staff documented in R #62's care plan R #62 served in the United States Military. The team will utilize the information obtained from Military Service Tool to identify stressors or combat related injuries that may impact the Veteran emotionally and/or physically and will determine the best approach for team members to deliver individualized care to [sic]. 2. On 08/19/24, staff documented in R #62's care plan R #62's had an order for paroxetine for depression/anxiety. a. Interventions included: i. Administer medication as ordered. ii. Educate R #62 about risks, benefits, and side effects of the medication. iii. Monitor for adverse reactions to the medication. 3. Staff did not document to monitor R #62 for the effectiveness of paroxetine. 4. Staff did not document R #62's diagnoses of bipolar disorder and PTSD. 5. Staff did not document to monitor behaviors related to R #62's mental health diagnoses. 6. Staff did not document any non-pharmacological interventions to implement when R #62 shows symptoms of depression, bipolar disorder, or PTSD. II. On 12/02/24 at 11:49 AM, during an interview with LPN #16, the following was revealed: 1. R #62 seems depressed occasionally. 2. Staff try to get R #62 out of his room to keep him busy with activities. 3. R #62 seems most depressed when he is in pain and will refuse to get out of bed. 4. Staff provide R #62 pain medication. 5. When R #62 refuses to get out of bed, staff notify the provider. 6. Staff also notify the Chaplain or social worker to speak to R #62 when he is depressed. 9. She confirmed that R #62's care plan did not include R #62 had diagnoses of bipolar disorder or PTSD. 10. She confirmed the only interventions in R #62's care plan for his diagnosis of depression were to provide medication and monitor for side effects of the medication. 11. She confirmed staff did not revise R #62's care plan to include the intervention to have the Chaplain or social worker speak to R #62 when he showed signs of depression. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	JJ. On 12/02/24 at 1:15 PM, during an interview with the DON, he confirmed the following: 1. R #62's mood fluctuated frequently. 2. R #62's care plan included that he took paroxetine for depression/anxiety. 3. He confirmed staff did not revise R #62's care plan to include the intervention to have the Chaplain or social worker speak to R #62 when he showed signs of depression. 4. R #62's care plan did not include his diagnoses of bipolar disorder order, PTSD, or any interventions in place for these diagnoses. 47510 49313

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41755 Based on observations, record reviews, and interviews, the facility failed to meet professional standards of quality for 4 (R #18, R #48, R #51 and R #87) of 4 (R #18, R #48, R #51 and R #87) residents when staff failed to: 1. Notify the physician when medication was not available for R #18 and R #48. 2. Administer medications according to physician's orders for R #51 and R #87. 3. Notify the physician when R #51 refused medication. If the facility is not providing care that meets professional standards of quality, then residents are likely to experience adverse effects, worsening of their condition, and potential complications from not receiving the care ordered by the physician. The findings are: R #18 A. Record review of R #18's admission record, no date, revealed R #18 was admitted to the facility 08/26/24. B. Record review of R #18's physician orders revealed an order, start date of 08/18/24, for amitriptyline 25 mg. Give one tablet by mouth one time a day for neuropathy (nerve damage that affects the hands and feet and causes pain, tingling, and burning sensation.) C. Record review of R #18's medication administration record (MAR; a form used to document medication administration), dated August 2024, revealed staff documented the following: 1. On 08/11/24, amitriptyline not administered, see progress notes. 2. On 08/12/24, amitriptyline not administered, see progress notes. 3. On 08/14/24, amitriptyline not administered, see progress notes. 4. On 08/15/24, amitriptyline not administered, see progress notes. D. Record review of R #18's progress notes, dated August 2024, revealed staff documented the following for R #18's amitriptyline: 1. On 08/11/24, awaiting pharmacy delivery. 2. On 08/12/24, on order. 3. On 08/14/24, medication is on order. 4. On 08/15/24, medication not available. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R #48 E. On 11/19/24 at 10:52 AM, an observation and interview with R #48 revealed the following: 1. R #48's legs were swollen. 2. R #48 did not wear compression stockings. 3. R #48 said he had orders for medication for the swelling in his legs. F. Record review of R #48's physicians orders, multiple dates, revealed the following: 1. An order dated 06/03/24 to 06/06/24, for furosemide (medication used to treat fluid retention (edema) and swelling caused by congestive heart failure, liver disease, kidney disease, and other medical conditions,) 40 mg once a day for edema to both legs. 2. An order dated 06/06/24, for furosemide, 20 mg once a day for edema to both legs. 3. An order dated 07/22/24 to 08/22/24, for furosemide, 40 mg once a day for 30 days for Acute Kidney Failure. 4. An order dated 08/23/24 to 08/28/24, for furosemide, 40 mg once a day for five days for edema related to Acute Kidney Failure. 5. An order dated 09/23/24 to 09/26/24, for furosemide, 40 mg twice a day for edema in both legs. 6. An order dated 09/26/24, for furosemide, 40 mg once a day for edema in both legs. 7. An order dated 10/15/24 to 10/17/24, furosemide, 40 mg twice a day for three days for edema in both legs. 8. An order dated 11/06/24, for compression stockings (tighter than average socks. They gently squeeze your legs to help your blood flow back toward your heart) one time a day. 9. An order dated 11/08/24 to 11/18/24, for metolazone (medication used to treat fluid retention and swelling that is caused by congestive heart failure, kidney disease, or other medical conditions,) 5 mg in the morning for 10 days for edema. G. Record review of R #48's medication administration record (MAR), dated November 2024, revealed staff documented the following: 1. R #48's metolazone was unavailable on the following dates: a. 11/08/24. b. 11/09/24. c. 11/10/24. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	d. 11/11/24. H. Record review of R #48's nursing progress notes, no date, revealed staff did not document they contacted the pharmacy or the provider that R #48's metolazone was unavailable. I. Record review of R #48's physician orders, no date, revealed staff did not enter another order to ensure R #48 received the doses of metolazone that were missed on 11/08/24, 11/09/24, 11/10/24, and 11/11/24. J. On 12/02/24 at 12:23 PM, during an interview, LPN #17 stated the following: 1. R #48 had edema in both legs. 3. R #48 had an order for compression stockings to alleviate edema. 4. R #48 had an order for furosemide for the edema in his legs. 5. She confirmed R #48 had an order for metolazone for 10 days starting on 11/08/24 through 11/18/24. 6. She confirmed R #48 did not receive metolazone on 11/08/24, 11/09/24, 11/10/24, and 11/11/24 due to the medication being unavailable. 7. She confirmed R #48 did not have another order for metolazone to ensure R #48 received the missed medciation doses. 8. She stated that if a medication was ordered and the medication did not arrive from the pharmacy, staff were expected to: a. Check the medication storage device to see if the medication was available there. b. If not available in the medication storage device, staff were expected to call the pharmacy to see why the medication did not arrive. c. To contact the provider to notify them the resident missed a dose of the medication and update the provider with the response from the pharmacy. d. Document in the resident's medical record the response from the pharmacy, the provider, and any new orders. 9. She confirmed staff did not document in R #48's medical record that they checked the medication storage device, contacted the pharmacy, or the provider. K. On 12/02/24 at 3:28 PM, during an interview with the DON, he confirmed the following: 1. Staff were expected to check the medication storage device for medications that did not arrive from the pharmacy. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
New Mexico State Veterans Home	992 South Broadway Truth OR Consequence, NM 87901

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Q. Record review of R #87's admission record, no date, revealed R #87 was admitted to the facility 04/09/24. R. Record review of R #87's physician orders revealed an order start date of 08/18/24 for Ditropan (medication that treats loss of bladder control) 5 mg. Give one tablet by mouth one time a day. Related neuromuscular dysfunction of the bladder (when the nerves or the brain cannot communicate effectively with the muscles in the bladder causing difficulty to control urination.) S. Record review of R #87's MAR, dated November 2024, revealed staff documented the following: 1. On 11/16/24, Ditropan not administered, see progress notes. 2. On 11/17/24, Ditropan not administered, see progress notes. 3. On 11/20/24, Ditropan not administered, see progress notes. T. Record review of R #87's progress notes, dated November 2024, revealed staff documented the following for R #87's Ditropan: 1. On 11/16/24, medication unavailable. 2. On 11/17/24, medication unavailable. 3. On 11/20/24, awaiting pharmacy. U. On 12/02/24 at 3:28 PM, during an interview with the DON, he stated the insulin should be given as ordered for R #51 and staff should notify the provider when R #51 refuses his trazodone. The DON also stated that staff should contact the pharmacy to inquire about the delay in receiving R #18 and R #87's medication delivery and staff should document in the resident's progress notes regarding their communication with the pharmacy. 49313

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F 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Plan the resident's discharge to meet the resident's goals and needs. 47510 Based on interview and record review, the facility failed to develop the resident's individualized discharge goals and needs for 1 (R #100) of 1 (R #100) resident reviewed for discharge planning. This deficient practice is likely to prevent a safe transition from the facility to the resident's post-discharge setting. The findings are: A. Record review revealed R #100 was discharged from the facility on 09/27/24. A. Record review of R #100's medical record, no date, revealed staff did not develop a discharge plan for R #100's discharge goals and needs. Record review revealed that the discharge summary, recapitulation of stay, and medications were not documented in the resident's medical record. B. On 11/21/24 at 9:38 am, during an interview, the DON confirmed R #100's discharge goals or needs were not documented in the residents' charts.

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F 0661 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure necessary information is communicated to the resident, and receiving health care provider at the time of a planned discharge. 47510 Based on record review and interview, the facility failed to ensure staff completed a discharge summary that included a recapitulation (a summary describing the resident's course of treatment while residing in the facility) and a reconciliation of all medication at the time of discharge for 1 (R #100) of 1 (R #100) residents sampled for discharge from the facility. This deficient practice could likely lead to the receiving facility, community agency, or family member not knowing what the current care needs and/or current medications are for the resident. The findings are: A. Record review of R #100's Electronic Medical Record (EMR) revealed the following: 1. R #100 was discharged from the facility on 09/27/24 to his home. 2. The record did not contain a recapitulation for of the resident's stay, medication list, or a discharge summary. 3. There is no documentation that R #100 was provided a discharge discharge summary. B. On 11/21/24 at 9:38 am, during an interview, the DON confirmed staff did not complete R #100's discharge summary at the time of discharge. The DON also stated staff should complete and sign the resident recapitulation of stay on the same day of the resident's discharge. The DON confirmed that there is not anything documenting that a discharge summary was provided to R #100.

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assist a resident in gaining access to vision and hearing services. 47510 Based on interview and record review, the facility failed to ensure residents received proper treatment to maintain hearing for 1 (R #78) of 3 (R #69, R #73, and R #78) residents reviewed for vision and hearing. This deficient practice could likely result in residents losing some independence if they cannot hear, which would compromise their quality of life. The findings are: A. On 11/19/24 at 9:20 am, during an interview, R #78 said he needed hearing aids, but he did not know why he did not have any hearing aids. R #78 said he had an appointment a year ago. R #78 said that he was supposed to get hearing aids but he never heard anything about them after the appointment. R #78 said he told staff several times that he needed hearing aids. B. Record review of R #78's progress note, dated 10/17/24, revealed R #78 complained that he needed hearing aids and had trouble getting them. The progress note did not include any intervention by staff to obtain hearing aides for the resident or refer the resident for an appointment to assess his hearing. C. On 12/02/24 at 2:50 pm, during an interview, CNA #8 said R #78 told her he needed hearing aids. CNA #8 said R #78 told her a couple of months ago. CNA #8 said she told the unit nurse at the time. CNA #8 does not remember the name of the nurse she told. D. Record review of R #78's medical record, no date, revealed the record did not contain any documentation of an appointment for R #78 to see an audiologist since he has been at the facility. E. On 12/02/24 at 1:00 pm, during an interview, Transportation said he did not see any documentation R #78 ever went to an audiologist appointment since he has been at the facility. F. On 12/02/24 at 5:03 pm, during an interview, the DON said the protocol was if a resident needed an appointment, then the resident told staff and staff let transportation know. The DON said that transportation was responsible for making appointiments for the residents and keeping track of them. The DON said he did not know why staff did not schedule an appointment for R #78.

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F 0742 Level of Harm - Actual harm Residents Affected - Some	Provide the appropriate treatment and services to a resident who displays or is diagnosed with mental disorder or psychosocial adjustment difficulty, or who has a history of trauma and/or post-traumatic stress disorder. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47510 49313 Based on record review and interview, the facility failed to provide adequate mental health services for 2 (R #62 and R #70) of 2 (R #62 and R #70) residents reviewed for mental health. This deficient practice likely resulted increased depression, hopelessness and psychosocial distress for R #62 and R #70. The findings are: R #62 A. Record review of R #62's admission documents, no date, revealed the following: 1. R #62 was admitted to the facility on [DATE]. 2. R #62 had the following diagnoses: a. Bipolar Disorder (serious mental illness characterized by extreme mood swings, that can include extreme excitement episodes or extreme depressive feelings). b. Depression (mood disorder that causes a persistent feeling of sadness and loss of interest). c. Dementia (term used to describe a group of symptoms affecting memory, thinking and social abilities). d. Post-Traumatic Stress Disorder (PTSD, mental health condition that develops following a traumatic event characterized by intrusive thoughts about the incident, recurrent distress/anxiety, flashback, and avoidance of similar situations). B. On 11/19/24 at 10:12 AM, during an interview with R #62, he stated the following: 1. The facility has not done anything for his mental health diagnoses or history of trauma. 2. Prior to coming to the facility, he used to receive therapy for his mental health diagnoses. 3. He confirmed that he is currently not receiving any behavioral health services and he believed that he would benefit from behavioral health services for his mental health diagnoses. C. Record review of R #62's nursing progress note, dated 9/10/24, revealed the following: 1. R #62 stayed in bed throughout the day shift. 2. R #62 refused lunch and refused to get out of bed. (continued on next page)

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F 0742 Level of Harm - Actual harm Residents Affected - Some	3. R #62 stated he was giving up. 4. R #62's Power of Attorney (POA, the authority to act for another person in specified or all legal or financial matters) was contacted to talk to R #62 since he was feeling alone. 5. R #62's POA was going to speak to family about requesting a psychiatric consultation (a meeting with a psychiatrist to evaluate a patient's mental health and provide a diagnosis and treatment recommendations) for R #62. 6. Staff did not document that they notified the provider about R #62's statements. D. Record review of R #62's social service progress note, dated 09/11/24, revealed the following: 1. The social worker (Chaplin) documented that he was notified that R #62 was depressed and done with life. 2. R #62 was not motivated and would barely talk to the social worker (Chaplin) the day before (09/10/24). 3. R #62 stated that he does not believe in God. 4. R #62 stated that he wanted to die. 5. Staff did not document that they notified the provider about R #62's statements. E. Record review of R #62's physician's order, dated 08/14/24, for Paroxetine (medication used to treat depression and other mental illnesses) 20 mg one time a day for depression/anxiety (an emotion characterized by feelings of tension, worried thoughts, and physical changes like increased blood pressure). F. Record review of R #62'd physician's orders, no date, revealed the following: 1. The physician did not order behavior monitoring for R #62's diagnoses of Bipolar Disorder, PTSD, or Depression. 2. The physician did not order monitoring for the effectiveness of Paroxetine for R #62. G. Record review of R #62's physician's progress note, dated 09/11/24, revealed the following: 1. The physician did not document that R #62 had a diagnosis of depression. 2. The physician did not document that R #62 was taking Paroxetine for his diagnosis of depression. 3. The physician documented that R #62 was feeling unwell with no specific symptoms. 4. The physician documented that the plan was to redirect behavioral issues appropriately. There were no new orders for an assessment or referral for mental health services. (continued on next page)

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F 0742 Level of Harm - Actual harm Residents Affected - Some	H. Record review of R #62's care plan, multiple dates, revealed the following: 1. On 06/25/24, staff documented R #62 served in the United States Military. The team will utilize the information obtained from Military Service Tool to identify stressors or combat related injuries that may impact the Veteran emotionally and/or physically and will determine the best approach for team members to deliver individualized care to [sic]. 2. On 08/19/24, staff documented an order for Paroxetine for depression/anxiety. a. Interventions included: i. Administer medication as ordered. ii. Educate R #62 about risks, benefits, and side effects of the medication. iii. Monitor for adverse reactions to the medication. 3. There was no intervention to monitor for symptoms of depression or refer resident to the social worker/chaplain or any psychological services. I. Record review of R #62's Care Plan Meeting note, dated 09/19/24, revealed R #62's POA requested an evaluation for R #62's diagnoses of bipolar disorder and dementia. J. Record review of R #62's entire medical record, no date, revealed: 1. R #62's medical record did not contain an order for a psychiatric consultation. 2. R #62's medical record did not contain any documentation that R #62 was evaluated by a psychiatric professional. 3. R #62's medical record did not contain any documentation that R #62 attended any behavioral health appointments or was seen by a behavioral health professional. K. On 12/02/24 at 11:49 AM, during an interview with LPN #16, the following was revealed: 1. R #62 seems depressed occasionally. 2. Staff try to get R #62 out of his room to keep him busy with activities. 3. R #62 seems most depressed when he is in pain and will refuse to get out of bed. 4. Staff provide R #62 pain medication. 5. When R #62 refuses to get out of bed, staff notify the provider. 6. Staff also notify the Chaplain to speak to R #62 when he appears depressed. 7. The facility does not have a psychiatric provider or counselor. (continued on next page)

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F 0742 Level of Harm - Actual harm Residents Affected - Some	8. R #62 was not receiving any psychiatric or behavioral health services. 10. She confirmed that the only interventions in R #62's care plan for his diagnosis of depression were to provide medication and monitor for side effects of the medication. L. On 12/02/24 at 1:15 PM, during an interview with the DON, he confirmed the following: 1. R #62's mood fluctuated frequently. 2. The social worker and the chaplain see residents when they are having mental health concerns. 3. The facility does not have any counseling or psychiatric services other than the social services worker and the chaplain. 4. R #62's care plan did not include interventions for R #62's diagnoses of depression other than giving medication and monitoring for side effects. 5. R #62's care plan did not include his diagnoses of bipolar disorder order, PTSD, or any interventions in place for these diagnoses. 6. R #62 did not have a psychiatric referral. 7. R #62 had not been evaluated by a psychiatric professional. 8. R #62 was not receiving mental health services. 9. Since R #62 was not suicidal, he would not expect staff to have referred him for behavioral health services or a psychiatric evaluation. R #70 M. Record review of R #70's physician orders, dated 06/28/24, revealed R #70 was admitted to hospice. N. On 11/19/24 at 10:20 am, during an interview, R #70 was tearful. R #70 said he wished he was dead. R #70 said he had not spoken to a counselor. R #70 said he just talked to staff. O. On 11/21/24 at 11:23 am, during an interview, CNA #9 said R #70 was more emotional in the last week or two. CNA #9 said R #70 told her he wished he was dead. CNA #9 said she reported to the unit nurse that R #70 said he wished he was dead. P. On 11/21/24 at 11:34 am, during an interview, LPN #8 said staff had told her R #70 was more down lately. LPN #8 said she was told that R #70 doesn't seem right but has not been told R #70 wishes he were dead. LPN #8 said she told hospice that R #70 was more sad lately. Q. Record review of R #70's medical record revealed the record did not contain any documentation that R #70 told staff he wished he was dead or that he seemed to be more sad than usual. The record did not contain any documentation that the facility provided any social services to R #70. (continued on next page)

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F 0742 Level of Harm - Actual harm Residents Affected - Some	R. Record review of an email sent from the Administrator dated 12/03/24, stated the facility staff had a discussion with hospice, and hospice stated this was the natural emotional state of an individual during the disease process. The Administrator said the facility provides a Chaplin to help the Veterans to relieve themselves of the emotional [NAME] and weight they carry from their war experience, and to assist in relief of the burden of guilt that they carry through their last moment of life. S. Record review of R #70's progress note, dated 10/02/24, revealed the Chaplin visited with R #70 on 10/02/24. The progress notes did not contain any documentation that R #70 visited with the Chaplin on a regular basis. T. On 11/21/24 at 11:50 am, during an interview, the DON said the facility was responsible for R #70's day-to-day care. The DON said R #70 should be provided mental health care, even if he was on hospice. The DON confirmed that R #70 was not receiving mental health care. U. On 12/06/24 at 11:07 am (after surveyor interviewed staff regarding R #70's mental health), during an interview with Hospice Nurse #8 (HN #8), he said that he was told on 11/22/24 that R #70 was telling staff that he wished he would just die. HN #8 said that he talked to R #70 on 11/27/24 and R #70 refused a referral for a psychiatric evaluation and medication. HN #8 said that he prayed with R #70 and told him he would continue to pray for him. V. On 12/20/24 at 1:55 pm, during an interview, the Assistant Administrator said that Social Services (SS #1) does not have a social work degree. The Assistant Administrator said that the Chaplin does not have a degree in social work and is not a licensed clinician.

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide or obtain dental services for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49313 Based on observation, interview, and record review, the facility failed to ensure residents obtained dental services for 1 (R #62) of 1 (R #62) residents sampled for dental services, when staff failed to schedule dental services for R#62's broken tooth. This deficient practice is likely to cause the resident unnecessary pain, embarrassment over the condition and/or appearance of teeth, and potential dental or oral complications. The findings are: A. Record review of R #62's admission record, no date, revealed R #62 was admitted to the facility on [DATE]. B. On 11/19/24 at 10:16 AM, an observation and interview with R #62 revealed the following: 1. R #62's bottom front tooth was broken. 2. The broken tooth was not causing any pain, but was annoying. 2. When he first arrived at the facility, R #62 told staff he had a broken tooth on one of his bottom front teeth (incisor tooth that is one of the most visible teeth when looking at a person) when he first arrived at the facility. 3. He told staff he wanted to see the dentist about his broken tooth. 4. He has not seen by a dentist since he arrived. C. Record review of R #62's nursing progress note, dated 03/22/24, revealed the following: 1. R #62 reported having a bottom tooth crack. 2. R #62 requested to see the dentist about his tooth. 3. The note did not include that the nurse was going to place an order for a referral to the dentist or request a referral to a densist. D. Record review of R #62's physician orders, no date, revealed R #62 did not have an order to be referred to the dentist [Required for resident to see a dentist, see finding E]. E. On 12/02/24 at 12:05 PM, during an interview with LPN #16, she confirmed the following: 1. When a resident requested to go to the dentist, the nurses should contact the provider and get an order. 2. The nurse should enter the order for referral in the resident's medical record. 3. Transportation was supposed to review the orders and schedule appointments. (continued on next page)

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4. R #62 did not have a dental referral order in his medical record. F. On 12/02/24 at 4:07 PM, during an interview with transportation, he confirmed the following: 1. He was not aware R #62 had a broken tooth. 2. R #62 was on the list to see the dentist for a routine annual dental appointment later in December 2024. G. On 12/02/24 at 5:06 PM, during an interview with the DON, he confirmed the following: 1. If a resident notified a staff member that they needed an appointment, then staff were expected to enter a referral order in the resident's medical record and notify transportation about the referral. 2. Transportation staff were expected to review all referral orders and schedule appointments for the residents. 3. Staff did not enter a referral order for R #62 to see the dentist.