STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	325103	A. Building B. Wing	07/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Life Care Center of Farmington	1101 West Murray Drive Farmington, NM 87401

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 38450 Based on observation and interview, the facility failed to ensure a resident was treated with respect and dignity for 3 (R #1, #20 and #21) of 3 (R #1, #20 and #21) residents observed during dining. This deficient practice could likely create a feeling of frustration, embarrassment, and disappointment. The findings are: A. On 07/08/24 at 12:20 pm, during lunch observation, Certified Nursing Assistant (CNA) #1 stood and fed two unknown residents. CNA #1 went back and forth between the two residents who sat at the same table. B. On 07/08/24 at 12:25 pm, during lunch observation, CNA #2 stood and fed an unknown resident. C. On 07/08/24 at 12:30 pm, during lunch observation, Nurse #3 brought a bedside tray table to an unknown resident. The resident sat in a reclining type chair. Nurse #3 stood while she fed the resident. D. On 07/08/24 at 12:38 pm, during an interview with Nurse #3, she stated she stood to feed the resident so she could see the other residents and make sure everyone was alright. E. On 07/08/24 at 1:15 pm, during an interview with the Administrator and and Director of Nursing (DON), they stated they were aware the staff stood and fed the residents. They stated it was their expectation that staff sat when they assisted the residents with eating.

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. 35632 Based on interview, the facility failed to investigate an injury of unknown origin for 1 (R #11) out of 3 (R #1, #11 and #12) residents reviewed for reporting to the State Agency. The deficient practice could cause residents to go without treatment and may expose them to injuries. The findings are: A. On 07/09/24 at 8:52 am, during an interview with the daughter of R #11, she stated she received a call from facility staff about 1:30 pm on 06/26/24 that something happened with her mother in the shower. She stated staff told her that her mother was fine, and there was not anything wrong with her. She stated staff told her since R #11 did not want the staff to touch her, they were going to send her mother out to the emergency room . She stated the physician from the hospital called her around 3:30 pm. The daughter stated when she got to the hospital, the hospital staff told her they needed to do surgery on her mother, because both of her mother's legs were fractured. The daughter stated she spoke to her mother in Navajo, and her mother told her the guy (unknown staff) who took care of her was not careful and dropped her. The daughter said her mother had a stroke at some point while in the hospital and passed away on 06/30/24. B. Record review of the medical records from the hospital for R #11, dated 06/27/24, indicated R #11 had bilateral femur fractures (broken bones in both legs). C. On 07/09/24 at 2:10 pm, during an interview with Director of Nursing (DON), she stated she was not sure when she was notified of R #11's pain. She stated to her knowledge an official investigation into the incident did not occur. She stated she saw Certified Nursing Assistant (CNA) #9 in the hall and stopped to speak with him about it. CNA #9 indicated that nothing out of the ordianry happened during the shower he gave R #11. The DON stated she did not speak to Licensed Practical Nurse (LPN) #10 who was the nurse on duty at that time. D. On 07/09/24 at 10:50 pm during an interview with the Administrator, he stated the facility did not conduct an investigation or submit a five day report (a report submitted to the State within 5 days after the initial incident) for this incident with R #11. The Administrator stated he did not feel like it was an injury of unknown origin, and they did not look into the incident any further.

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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 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35632 Based on record review and interview the facility failed to prevent an accident when staff did not provide appropriate care for 1 (R #12) out of 1 (R #12) resident looked at for accidents. This deficient practice caused R #12 to fall out of bed, hitting her head, and passing away at the hospital hours later. The findings are: A. Record review of the face sheet for R #12 indicated the resident was admitted on [DATE] with the following diagnoses: - Muscular dystrophy (a group of diseases that cause progressive muscle weakness and loss of muscle mass), - Obesity (overweight), - Chronic pain, - Cardiac pacemaker (regulates the heart), - Disc degeneration (disk in your spine start to wear out and cause and pain). B. Record review of the medical record for R #12 revealed the resident's weight was 285 pounds (lbs) as of 05/14/24. C. Record review of the quarterly Minimum Data Set (MDS; a federally mandated assessment instrument completed by facility staff) for R #12, dated 03/28/24, indicated the resident was dependent (two or more staff do all of the effort, and the resident does none of the effort to complete the activity) in the following areas: - Roll left and right: The ability to roll from lying on back position to the left and right sides and return to lying on back position on the bed. - Sit to lying: The ability to move from sitting position on the side of bed to lying flat on the bed. - Lying to sitting on side of bed: The ability to move from lying on the back position to sitting on the side of the bed and with no back support. D. Record review of the care plan intervention for R #12, dated 12/27/23, indicated the resident required the assistance from one or two staff with all activities of daily of living (ADLs; activities related to personal care such as bathing, showering, dressing, walking, toileting, and eating). E. Record review of the nursing progress notes for R #12, revealed the following: (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	- On 05/16/24 at 1:56 pm, late entry note, R #12 had a witnessed fall from the bed onto the floor. Certified Nursing Assistant (CNA) #3 notified the nurse on the unit of the fall that occurred during peri-care. R #12 rolled out of bed onto her left side, as staff assisted her with a brief change. R #12 was alert and oriented. R #12's left toe was bent backwards and bleeding. R #12 had abrasions on her left back shoulder, left temple, and left elbow. She required four staffs' maximum assistance to roll onto back, and staff assisted her off the floor with a mechanical lift (a device which assists care givers to transfer residents). Staff notified the provider, started the paperwork to transfer R #12 to the hospital, and notified emergency medical services (EMS). - On 05/16/24 at 2:14 pm, CNA #3 called for the nurse to report the resident rolled out bed during a brief change. Nurse assessed R #12. The resident was able to follow every direction and answer questions appropriately. The resident's arms were strong equally, but she was only able to bend the right leg without issues. The resident was not able to bend the left leg without issues. The resident's third toe on her left foot was bent backward, and R #12 stated it was really painful to the touch. The resident's left shoulder was painful, and R #12 had a hematoma (bruise: localized bleeding outside of blood vessels, due to either disease or trauma) on top of her left eye with a small abrasion. F. Record review of the hospital nursing progress note for R #12, dated 05/16/24 indicated R #12 arrived at the hospital unit from the emergency room and was obtunded (diminished responsiveness to stimuli), including painful stimuli. R #12's heart rate was 120 to 130 beats per minute (bpm) range (normal heart rate is 70 to 90 bpm), and her oxygenation (amount of oxygen in the blood) was in the 50 to 70 range (normal range is between 90 and 100%). R #12 passed away on 05/16/24 at 19:49 (7:49 pm). G. On 07/09/24 at 10:45 am during an interview with the Director of Nursing (DON), she stated a CNA went to change R #12. The CNA pulled the bed away from the wall and asked R #12 to roll herself onto her side. CNA #3 started to clean the resident, and R #12 rolled off the bed. The DON stated pulling the bed away from the wall was not standard practice. The DON stated CNA #3 asked R #12 if she was able to roll, and the resident stated yes. The DON stated she did not think the CNA should have moved the bed away from the wall unless there was another person present on the other side. H. On 07/09/24 at 2:25 pm, during an interview with CNA #3, she stated she worked with R #12 on 05/16/24 . She stated she was doing her last rounds, and it was shift change. CNA #3 stated she checked R #12, and the resident needed to be changed. She stated that one side of R #12's bed was against the wall, and she moved the bed away from the wall, raised the bed up higher, and locked the bed wheels before she started to change the resident. CNA #3 stated if she needed to access to the other side of the bed, then she will pull the bed away from the wall. She said she asked R #12 if she could hold herself on her side, and the resident said yes. CNA #3 stated she cleaned R #12 up and went around the bed to the other side to continue to clean her up. CNA #3 stated R #12 started to roll over (forward from her side), and she could not stop the resident. CNA #3 stated R #12 fell to the ground and hit her head. CNA #3 stated she notified the nurse immediately. CNA #3 stated she typically changed R #12 with another person; however, it was shift change, and everyone was busy. CNA #3 stated she decided to change the resident alone. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	I. On 07/11/24 at 10:25 am, during an interview with CNA #5, she stated she always used two people when she did pericare (cleaning the private areas) on a resident. She stated she would never move the bed away from the wall, unless there was another person with her to stand on the other side with the resident. She stated she worked with R #12 before, and the resident would not provide assistance when she was changed. CNA #5 stated R #12 was a heavier lady and did not have much strength. CNA #5 stated she would never change R #12 alone, because the resident absolutely required two people to change her. J. On 07/11/24 at 10:37 am, during an interview with CNA #4, she stated if there was a larger resident who was not very strong and unable to assist with pericare, then she would not change them alone. She stated she would always ask someone for help. She stated she never did pericare alone for safety reasons. CNA #4 also stated if she did not have another person to be on the other side of the resident's bed, then she would not move the bed away from the wall. K. On 07/11/24 at 10:43 am, during an interview with CNA #6, she stated she would not move the resident's bed away from the wall if it was just her doing pericare. She stated she worked with R #12 before, and she would not change her alone. She stated there was always another staff available to assist if needed help, such as the nurses.

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F 0697 Level of Harm - Actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35632 Based on record review and interview the facility failed to thoroughly assess the pain level of 2 (R #1 and #11) of 2 (R #1 and #11) residents looked at for an injury of unknown origin and pain, when staff: 1. Pulled on R #1's arm to assist him to get out of bed after complained of pain in his arm. 2. Allowed R #11 to sit in severe pain for several hours before the physician saw the resident and sent her to the emergency room for x-rays. The findings are: Findings for R #1 A. Record review of the medical record face sheet for R #1 revealed he was admitted on [DATE]. He was admitted with the following diagnoses: - Dementia (symptoms affecting memory, thinking and social abilities severely enough to interfere with your daily life), - Difficulty walking, - Communication deficit, - Intracerebral hemmorrhage (a brain bleed and a type of stroke. It causes blood to pool between your brain and skull and prevents oxygen from reaching your brain it is life-threatening), - Type II diabetes (when the body does not use insulin properly) - Parkinson's disease (a progressive disorder that affects the nervous system and the parts of the body controlled by the nerves) - Neuromuscular dysfuntion of bladder (is when a problem in your brain, spinal cord, or central nervous system makes you lose control of your bladder). - This is not an all inclusive list. (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	B. On 07/09/24 at 5:18 pm, during an interview with Power of Attorney (POA)/Family Member, she stated she was very upset when she saw a video on 06/17/24 where staff assisted R #1 with getting up by pulling his right arm. She stated she called the facility immediately told them to stop pulling the resident by his right arm to get him up. She stated she could tell the resident was in pain on the video, and she could hear him speaking in Spanish that he was in pain. She stated when she got back into town on 06/22/24, she took R #1 to get a new set of x-rays on his right shoulder and ribs, because the resident complained of pain. The POA stated R #1 had extensive bruising over his right side. She stated R #1's shoulder was not asymmetrical (same), because his right shoulder had a bump on top. She stated she was concerned that it was a fracture. C. Record review of a video from the video camera in R #1's room revealed the following: - On 06/19/24 at 8:35 am, R #1 was in pain (evident by grimacing and did not want to get out of bed.) CNA #2 encouraged the resident to get up and pulled on R #1's right arm to assist him to get up. R #1 indicated he did not want to get up and was in pain. R #1 told CNA #2 that he was in pain. CNA #2 encouraged R #1 to get into his wheelchair so they could go to the nurse's station to get pain medication. - On 06/20/24 at 10:15 pm, Nurse #9 pulled on R #1's right arm to get him out of bed and told him to get up. D. Record review of photos taken by the POA/Family Member of R #1 taken on 06/22/24 indicated extensive bruising on R #1's right side. He had dark purple bruising on his right side shoulder blade area, top of his shoulder, under his arm. The back of his arm had dark purple bruising, yellow bruising on his shoulder and rib/chest area, and had yellow burising on his right temple. He had scabs and both yellow and purple bruising on his right elbow. E. Record review of the pain scale (zero meant no pain, and 10 meant the worst possbbile) for R #1 indicated the following: - The resident did not typically report pain, with staff documenting R #1's pain to be 0, no pain. - On 06/14/24, the resident reported pain four times from 1:15 pm to 11:47 pm. - On 06/17/24, the resident reported his pain to be a 5. - On 06/18/24, the resident reported his pain to be a 2. - On 06/20/24, the resident report his pain to be a 3. F. Record review of the orthopedic physician notes, dated 06/26/24, indicated R #1 complained of right clavicle pain, right side rib pain, and elbow pain due to multiple falls. G. Record review of the orthopedic physician orders, dated 06/26/24, indicated R #1 should remain in a sling, with no pulling or lifting using right side due to fracture at right clavicle and elbow and no using right upper extremity. The resident would be non-weight bearing with right upper extremity (right arm), and staff were to have R #1 lean more to the left side. (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	H. Record review of R #1's x-rays, dated 07/23/24, revealed the following: - R #1's right shoulder: a communicated fracture (fracture refers to a bone that is broken in at least two places), of the distal clavicle (break in the collarbone, one of the main bones in the shoulder) with adjacent soft tissue swelling. - R #1's right ribs and chest area: an oblique lucency (fracture across the width of the bone with low density) is in the fourth rib. Cortical irregularity (constant traction of the soft tissue attachments) of the lateral third rib. Displaced lateral fifth rib fracture (a rib bone breaks and becomes misaligned or shifts from its normal position, leading to significant chest pain and potential breathing difficulties) and cortical step-off in the sixth lateral rib (minimally displaced fracture). Displaced second rib fracture. I. On 07/11/24 at 1:42 pm, during an interview with CNA #2, she stated she was aware R #1 had fallen on 06/14/24 and 06/17/24. She stated she was told he fell but was not given any other information. CNA #2 stated the resident had a sling on his right arm, but he did not keep the sling on much. She stated she was not aware of the extent of R #1's injuries at that time. CNA #2 stated she tried to pull R #1 up by his arm on 06/19/24 and the next day 06/20/24 she was told to stop pulling on his arm by the nurse. CNA #2 stated R #1's POA called the nursing station to report she saw CNA #2 pull R #1 up by his arm on the video. CNA #2 stated R #1 was very bruised on 06/19/24. She stated that they do use gait belts to assist with getting residents up but it didn't work well with him (she did not clarify why it was hard). J. On 07/11/24 at 2:03 pm, during an interview with Nurse #3, she stated there was not any specific training given to the CNAs or nurses around R #1's bruising and concerns to his right side. She stated R #1 still used his right arm and did not seem to be in any pain. Nurse #3 stated they did not receive any specific training on how to assist with transferring of R #1 after they found out about his broken clavicle (shoulder) and broken ribs. Findings for R #11 K. Record review of the Face Sheet for R #11 indicated R #11 was admitted on [DATE]. She had the following diagnoses: - Dementia, - Heart disease, - Cardiac pacemaker (small, battery-powered device that prevents the heart from beating too slowly), - Diabetes, - Long term use of anticoagulants (medicines that increase the time it takes for blood to clot). - This is not an all inclusive list. (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	L. Record review of the quarterly Minimum Data Set (MDS; a federally mandated assessment instrument completed by facility staff) for R #11, dated 04/18/24, indicated R #11 required maximum assistance (helper does more than half the effort) with most of her activities of daily living (ADLs; activities related to personal care such as bathing, showering, dressing, walking, toileting, and eating), to include showering and bathing. R #11 was always incontinent (can not control urine or feces) of bowel and most of the time incontinent of bladder. M. On 07/09/24 at 8:52 am, during an interview with the daughter of R #11, she stated she received a call from facility staff about 1:30 pm on 06/26/24 that something happened with her mother in the shower. She stated staff told her that her mother was fine, and there was not anything wrong with her. She stated staff told her since R #11 did not want the staff to touch her, they were going to send her mother out to the emergency room . She stated the physician from the hospital called her around 3:30 pm. The daughter stated when she got to the hospital, the hospital staff told her they needed to do surgery on her mother, because both of her mother's legs were fractured. The daughter stated she spoke to her mother in Navajo R #11, and her mother told her the guy (unknown staff) who took care of her was not careful and dropped her. The daughter said her mother had a stroke at some point while in the hospital and passed away on 06/30/24. N. Record review of the nursing progress notes for R #11, dated 06/26/24 at 11:50 am, indicated R #11 complained of severe pain to both knees, and the left was worse than the right. Resident cried out and yelled out. Resident had a history of bilateral knee surgeries. Unable to assess knees as resident pushed nurse hands away to check for swelling. Asked if she would try Bengay for pain, and the resident did not want nursing staff to touch her knees. Resident wanted to have a towel under her feet as her feet dangled down. The resident would not let staff put her feet on footrest because of increase pain with movement. Resident was left sitting near nurses station and did not want to be wheeled in her wheelchair sinced it caused increase pain in her knees. The resident did not want to be taken into the dining room for lunch. Physician would be in and assess pain medication. O. Record review of the nursing progress notes for R #11 indicated the resident was sent to the hosptial after the physician assessed her. Director of Nursing (DON) was notified at 1:19 pm, and emergency medical services was notified at 1:20 pm. P. Record review of the Medical Records from the hopsital, dated 06/27/24, indicated R #11 had bilateral femur fractures (broken bones in both legs). Resident was admitted to the hopsital on 06/26/24 at 14:01 (2:01 pm). Q. On 07/09/24 at 2:10 pm, during an interview with DON, she stated she was not sure of when staff notified her of R #11's pain. She stated if R #11 was in a lot of pain, she wished staff notified her sooner. The DON stated she knew the Medical Director (MD) was in the building and told the nurse the MD needed to see R #11. The DON stated the nurse wrote a progress note in reference to R #11, and it indicated R #11 was in a lot of pain. R. Record review of the physician orders for R #11 revealed the following orders: - An order for acetaminophen, 325 mg start date 12/13/23, two tablets every four hours by mouth. - An order for Tramadol, 50 mg. Give one tablet by mouth every eight hours as needed for moderate to severe pain, dated 06/26/24 at 12:52 pm. (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	S. Record review of the medication administration record (MAR) for R #11, dated 06/01/24 to 06/26/24, revealed the following: - Staff administered a dose of acetaminophen to R #11 on 06/26/24 at 12:21 am, 8:59 am, and 12:59 pm. - Staff did not administer a dose of the Tramadol before resident left to go to the hosptial. T. On 07/10/24 at 8:20 am, during an interview with Nurse #10, she stated Certified Nursing Assistant (CNA) #9 and CNA #10 transferred R #11 back into the wheelchair after her shower. The nurse stated when the CNAs brought the resident out of the shower, R #11 complained of knee pain. Nurse #10 stated R #11 was in a lot of pain, and the resident told her the pain was in both knees, with one of them hurting more than the other. Nurse #10 stated she could not give the resident any more Tylenol, because R #11 already received it that morning. Nurse #10 stated she called the physician. She said he was in a meeting, but she knew he was in the building that day. She stated the physician saw R #11, and she was in a lot of pain. The physician ordered Tramadol for R #11, but R #11 was sent out and did not receive the Tramadol. U. On 07/10/24 at 8:45 am, during an interview with CNA #9, he stated he came to work on 06/26/24 around 8:30 am. He said he immediately looked at the shower list, and R #11 was on it. He said the resident was complaining of pain when he arrived that day so the nurse gave R #11 a Tylenol for the pain. He said he gave R #11 a shower around 9:00 am. He stated the resident required two people for transferring in the shower. He stated another CNA (he did not know who) helped him get R #11 into the shower chair. CNA #9 stated after the shower, he turned on the call light, and CNA #10 helped him get R #11 dressed and back into her wheelchair. CNA #9 stated he worked with R #11, and she never complained of pain. He said R #11 was in a lot of pain, and the nurse told the resident she could not give her anything else for the pain. CNA #9 stated the nurse told R #11 the physician would be in to see her. He said R #11 cried out in pain and got really loud. CNA #9 stated they sent the resident out to the hospital hours later, but she was in a lot of pain that whole time. CNA #9 stated R #11 did not fall in the shower. V. On 07/10/24 at 11:40 am during an interview with the Physician, he stated he could not remember what time he saw (it was around lunch time, maybe 12:30 pm) R #11 on 06/26/24, but she was complaining of knee pain. He said R #11 was in severe pain, cried, and pointed to her knee. The Physician stated R #11 spoke Navajo, and he had a staff member translate for him. He stated the resident did not say anything other than she was in pain. He stated he sent R #11 out to get x-rays, and she had a fracture. He said he suspected the resident fell , but staff did not report a fall to him. He stated a fall or a twisting motion might have caused that kind of femur fracture. W. On 07/10/24 at 11:31 am, during an interview with the Director of Rehabilitation (DOR), she stated that she heard R #11 crying and screaming out out in pain on 06/26/24, and she went to check on the resident. The DOR stated R #11 pointed to her leg but did not want anyone to touch her leg or to look at it. She said the timeframe was between 9:00 am and 11:00 am.

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F 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35632 Based on interview and record review, the facility failed to ensure that nursing staff had the competencies required to ensure 2 (R #1 and R #12) out of 2 (R #1 and R #12) residents received care that met the health and safety needs of the residents when staff failed to: - Prevent R #12 from rolling off the bed, causing a serious head injury that resulted in death. - Position R #1's catheter leg bag (a bag that is attached to the leg and catches urine) below his catheter (tube placed in the bladder to drain urine from the bladder) while he was in bed, which could cause urine to back up into the bladder and cause an infection. - Properly assist R #1 with standing, which caused him pain. The findings are: Findings for R #12 A. Record review of the face sheet for R #12 indicated the resident was admitted on [DATE] with the following diagnoses: - Muscular dystrophy (a group of diseases that cause progressive muscle weakness and loss of muscle mass), - Obesity (overweight), - Chronic pain, - Cardiac pacemaker (regulates the heart), - Disc degeneration (disk in your spine start to wear out and cause and pain). B. Record review of the medical record for R #12 revealed the resident's weight was 285 pounds (lbs) as of 05/14/24. C. Record review of the quarterly Minimum Data Set (MDS; a federally mandated assessment instrument completed by facility staff) for R #12, dated 03/28/24, indicated the resident was dependent (two or more staff do all of the effort, and the resident does none of the effort to complete the activity) in the following areas: - Roll left and right: The ability to roll from lying on back position to the left and right sides and return to lying on back position on the bed. - Sit to lying: The ability to move from sitting position on the side of bed to lying flat on the bed. (continued on next page)

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F 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	- Lying to sitting on side of bed: The ability to move from lying on the back position to sitting on the side of the bed and with no back support. D. Record review of the care plan intervention for R #12, dated 12/27/23, indicated the resident required the assistance from one or two staff with all activities of daily of living (ADLs; activities related to personal care such as bathing, showering, dressing, walking, toileting, and eating). E. Record review of the nursing progress notes for R #12, revealed the following: - On 05/16/24 at 1:56 pm, late entry note, R #12 had a witnessed fall from the bed onto the floor. Certified Nursing Assistant (CNA) #3 notified the nurse on the unit of the fall that occurred during peri-care. R #12 rolled out of bed onto her left side, as staff assisted her with a brief changed. R #12 was alert and oriented. R #12's left toe was bent backwards and bleeding. R #12 had abrasions on her left back shoulder, left temple, and left elbow. She required four staffs' maximum assistance to roll onto back, and staff assisted her off the floor with a mechanical lift (a device which assists care givers to transfer residents). Staff notified the provider, started the paperwork to transfer R #12 to the hospital, and notified emergency medical services (EMS). - On 05/16/24 at 2:14 pm, CNA #3 called for the nurse to report the resident rolled out bed during a brief change. Nurse assessed R #12. The resident was able to follow every direction and answer questions appropriately. The resident's arms were strong equally, but she was only able to bend the right leg without issues. The resident was not able to bend the left leg without issues. The resident's third toe on her left foot was bent backward, and R #12 stated it was really painful to the touch. The resident's left shoulder was painful, and R #12 had a hematoma (bruise: localized bleeding outside of blood vessels, due to either disease or trauma) on top of her left eye with a small abrasion. F. Record review of the hospital medical records for R #12, dated 05/16/24 at 3:58 pm, indicated the following: - An acute large subdural hemorrhage (bleeding that occurs in the membranes surrounding the brain) resulting in uncal herniation [life threatening trauma causing the brain to shift and herniate (an organ or fatty tissue squeezes through a weak spot in a surrounding muscle or connective tissue)] and midline shift (pressure from the hematoma pushes the brain off-center) measuring 1.4 centimeter (cm). There was trace subarachnoid hemorrhage [bleeding within the subarachnoid space (the area between the brain and the tissue covering the brain)] present with the left frontal lobe (the front part of the brain) and no intraventricular extension [bleeding into the brain's ventricular system (an interconnected series of cavities filled with cerebrospinal fluid (CSF) that cushions the brain.)] - Medical decision making: R #12 was prepped for transport to a different hospital in another city. R #12 was going to be intubated and placed on a ventilator for the transport. R #12's father had a conversation with the physician about comfort measures. The physician did a repeat of the exam, and R #12's pupils (the black opening in the middle of the colored part of your eye) bilaterally (both pupils) were dilated (open) and non-reactive [did not get smaller with light; a sign of severe traumatic brain injury (TBI), usually considered a sign of irreversible brain damage and strongly associated with a very poor outcome (death, vegetative state, or severe disability) in most patients.] The physician told the father he did not think R #12 would survive the transfer. She was placed on comfort measures. (continued on next page)

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F 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	G. Record review of the hospital nursing progress note for R #12, dated 05/16/24 indicated R #12 arrived at the hospital unit from the emergency room and was obtunded (diminished responsiveness to stimuli), including painful stimuli. R #12's heart rate was 120 to 130 beats per minute (bpm) range (normal heart rate is 70 to 90 bpm), and her oxygenation (amount of oxygen in the blood) was in the 50 to 70 range (normal range is between 90 and 100%). R #12 passed away on 05/16/24 at 19:49 (7:49 pm). H. On 07/09/24 at 10:45 am during an interview with the Director of Nursing (DON), she stated a CNA went to change R #12. The CNA pulled the bed away from the wall and asked R #12 to roll herself onto her side. CNA #3 started to clean the resident, and R #12 rolled off the bed. The DON stated pulling the bed away from the wall was not standard practice. The DON stated CNA #3 asked R #12 if she was able to roll, and the resident stated yes. The DON stated she did not think the CNA should have moved the bed away from the wall unless there was another person present on the other side. I. On 07/09/24 at 2:25 pm, during an interview with CNA #3, she stated she worked with R #12 on 05/16/24 . She stated she was doing her last rounds, and it was shift change. CNA #3 stated she checked R #12, and the resident needed to be changed. She stated that one side of R #12's bed was against and the wall and before she started to change her she moved the bed away from the wall, raised the bed up higher, and locked the bed wheels. CNA #3 stated that if she needed to access to the other side of the bed, then she will pull the bed away from the wall. She said she asked R #12 if she could hold herself on her side, and the resident said yes. CNA #3 stated she cleaned R #12 up and went around the bed to the other side to continue to clean her up. CNA #3 stated R #12 started to roll over (forward from her side), and she could not stop her. CNA #3 stated R #12 fell to the ground and hit her head. CNA #3 stated she notified the nurse immediately. CNA #3 stated she typically changed R #12 with another person; however, it was shift change, and everyone was busy. CNA #3 stated she decided to change the resident alone. J. On 07/11/24 at 10:25 am, during an interview with CNA #5, she stated she always used two people when she did pericare (cleaning the private areas) on a resident. She stated she would never move the bed away from the wall, unless there was another person with her to stand on the other side with the resident. She stated she worked with R #12 before, and the resident would not provide assistance when she was changed. CNA #5 stated R #12 was a heavier lady and did not have much strength. CNA #5 stated she would never change R #12 alone, because the resident absolutely required two people to change her. K. On 07/11/24 at 10:37 am, during an interview with CNA #4, she stated if there was a larger resident who was not very strong and unable to assist with pericare, then she would not change them alone. She stated she would always ask someone for help. She stated she never did pericare alone for safety reasons. CNA #4 also stated if she did not have another person to be on the other side of the resident's bed, then she would not move the bed away from the wall. L. On 07/11/24 at 10:43 am, during an interview with CNA #6, she stated she would not move the resident's bed away from the wall if it was just her doing pericare. She stated she worked with R #12 before, and she would not change her alone. She stated there was always someone [staff] available to assist if you needed help, such as the nurses. (continued on next page)

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F 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	M. On 07/10/24 at 2:13 pm, during an interview with the Nursing Educator (NE), she stated that when she stepped into the Educator role, she was told she needed to do a training on two person assist. She stated she was not sure what the issue was exactly. She stated she did not find issues with two person or Hoyer lift transferring. NE stated she was aware of the incident with CNA #3 and R #12 however she stated she was going to do training with everyone regarding brief changes, because she did not want to single out CNA #3 (who was the CNA involved in the fall with R #12). The Educator stated she training did not occur because she stepped down from the position. Findings for R #1's catheter leg bag. N. Record review of the medical record face sheet for R #1 revealed he was admitted on [DATE]. He was admitted with the following diagnoses: - Dementia (symptoms affecting memory, thinking and social abilities severely enough to interfere with your daily life) - Difficulty walking, - Communication deficit, - Intracerebral hemmorrhage (a brain bleed and a type of stroke. It causes blood to pool between the brain and skull and prevents oxygen from reaching the brain. It is life-threatening), - Type II diabetes (the body does not use insulin properly), - Parkinson's disease (a progressive disorder that affects the nervous system and the parts of the body controlled by the nerves) - Neuromuscular dysfuntion of bladder (a problem in the brain, spinal cord, or central nervous system which creates a loss of bladder control). - This is not an all inclusive list. O. Record review of the physician orders for R #1 indicated orders to change catheter bag as needed for infection, obstruction, or when the closed system is compromised. Keep catheter placed below the level of the bladder. Start date: 06/13/24. P. On 07/09/24 at 5:18 pm, during an interview with R #1's Power of Attorney (POA)/Family Member, she stated she saw numerous recordings from a video camera in R #1's room of staff putting the catheter leg bag on the resident. The POA stated staff come and put the leg bag on him early in the morning. She stated R #1 did not get out of bed for hours, so he lay there with the leg bag at the same height as the catheter. The POA stated the resident's catheter leg bag must be below the catheter, so it drained into the leg bag. She said if the leg bag was level with the catheter then it will drain back into his bladder and cause an infection. Q. Record review of a video from the video camera in R #1's room indicated the following: (continued on next page)

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F 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	- On 06/02/24 at 5:54 am, the resident transferred from his bed to the reclining chair and had on his catheter leg bag. - On 06/19/24 at 4:42 am, a Nurse (N) #9 placed a catheter leg bag on R #1. The resident lay in bed and slept. R #1 did not get out of bed at this time. - On 06/19/24 at 8:35 am, R #1 lay in bed and had on his catheter leg bag. R. On 07/11/24 at 1:42 pm, during an interview with CNA #2, she stated there were two nights last week, sometime between 07/01/24 and 07/07/24, when R #1 had his catheter leg bag on while he was asleep in bed. She stated she did not think staff took it off him the day before. S. On 07/11/24 at 3:30 pm the Director of Nursing (DON) stated she thought it was the CNAs who did not remove the catheter leg bag when they put R #1 to bed at night, but it was a nurse who did not remove it. The DON stated the catheter leg bag should be removed and connected to the bag hanging off of the bed. Findings for R #1 standing assistance. T. Record review of the medical record face sheet for R #1 revealed he was admitted on [DATE]. He was admitted with the following diagnoses: - Dementia (symptoms affecting memory, thinking and social abilities severely enough to interfere with your daily life) - Difficulty walking, - Communication deficit, - Intracerebral hemmorrhage (a brain bleed and a type of stroke. It causes blood to pool between the brain and skull and prevents oxygen from reaching the brain. It is life-threatening), - Type II diabetes (the body does not use insulin properly), - Parkinson's disease (a progressive disorder that affects the nervous system and the parts of the body controlled by the nerves) - Neuromuscular dysfuntion of bladder (a problem in the brain, spinal cord, or central nervous system which creates a loss of bladder control). - This is not an all inclusive list. (continued on next page)

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F 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	U. On 07/09/24 at 5:18 pm, during an interview with Power of Attorney (POA)/Family Member, she stated she was very upset when she saw a video on 06/17/24 where staff assisted R #1 with getting up by pulling his right arm. She stated she called the facility immediately told them to stop pulling the resident by his right arm to get him up. She stated she could tell the resident was in pain on the video, and she could hear him speaking in Spanish that he was in pain. She stated when she got back into town on 06/22/24, she took R #1 to get a new set of x-rays on his right shoulder and ribs, because the resident complained of pain. The POA stated R #1 had extensive bruising over his right side. She stated R #1's shoulder was not asymmetrical (same), because his right shoulder had a bump on top. She stated she was concerned that it was a fracture. V. Record review of R #1's x-rays, dated 07/23/24, revealed the following: - R #1's right shoulder: a communicated fracture (fracture refers to a bone that is broken in at least two places), of the distal clavicle (break in the collarbone, one of the main bones in the shoulder) with adjacent soft tissue swelling. - R #1's right ribs and chest area: an oblique lucency (fracture across the width of the bone with low density) is in the fourth rib. Cortical irregularity (constant traction of the soft tissue attachments) of the lateral third rib. Displaced lateral fifth rib fracture (a rib bone breaks and becomes misaligned or shifts from its normal position, leading to significant chest pain and potential breathing difficulties) and cortical step-off in the sixth lateral rib (minimally displaced fracture). Displaced second rib fracture. W. Record review of the pain scale (zero meant no pain, and 10 meant the worst possible) for R #1 indicated the following: - The resident did not typically report pain, with staff documenting R #1's pain to be 0, no pain. - On 06/14/24, the resident reported pain four times from 1:15 pm to 11:47 pm. - On 06/17/24, the resident reported his pain to be a 5. - On 06/18/24, the resident reported his pain to be a 2. - On 06/20/24, the resident report his pain to be a 3. X. Record review of the orthopedic physician notes, dated 06/26/24, indicated R #1 complained of right clavicle pain, right side rib pain, and elbow pain due to multiple falls. Y. Record review of the orthopedic physician orders, dated 06/26/24, indicated R #1 should remain in a sling, with no pulling or lifting using right side due to fracture at right clavicle and elbow and no using right upper extremity. The resident would be non-weight bearing with right upper extremity (right arm), and staff were to have R #1 lean more to the left side. Z. Record review of a video from the video camera in R #1's room revealed the following: (continued on next page)

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F 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	- On 06/19/24 at 8:35 am, R #1 was in pain (evident by grimacing and did not want to get out of bed.) CNA #2 encouraged the resident to get up and pulled on R #1's right arm to assist him to get up. R #1 indicated he did not want to get up and was in pain. R #1 told CNA #2 that he was in pain. CNA #2 encouraged R #1 to get into his wheelchair so they could go to the nurse's station to get pain medication. - On 06/20/24 at 10:15 pm, Nurse #9 pulled on R #1's right arm to get him out of bed and told him to get up. AA. On 07/11/24 at 1:42 pm, during an interview with CNA #2, she stated she was aware R #1 had fallen on 06/14/24 and 06/17/24. She stated she was told he fell but was not given any other information. CNA #2 stated the resident had a sling on his right arm, but he did not keep the sling on much. She stated she was not aware of the extent of R #1's injuries at that time. CNA #2 stated she tried to pull R #1 up by his arm on 06/19/24 and the next day 06/20/24 she was told to stop pulling on his arm by the nurse. CNA #2 stated R #1's POA called the nursing station to report she saw CNA #2 pull R #1 up by his arm on the video. CNA #2 stated R #1 was very bruised on 06/19/24. She stated that they do use gait belts to assist with getting residents up but it didn't work well with him (she did not clarify why it was hard). BB. Record review of photos taken by the POA/Family Member of R #1, taken on 06/22/24, indicated extensive bruising on R #1's right side. He had dark purple bruising on his right side shoulder blade area, top of his shoulder, under his arm. The back of his arm had dark purple bruising, yellow bruising on his shoulder and rib/chest area, and had yellow bruising on his right temple. He had scabs and both yellow and purple bruising on his right elbow. CC. On 07/11/24 at 2:03 pm, during an interview with Nurse #3, she stated that there was not any specific training given to the CNAs or nurses around R #1's bruising and concerns to his right side. She stated R #1 still used his right arm and did not seem to be in any pain. Nurse #3 stated they did not receive any specific training on how to assist with transferring of R #1 after they found out about his broken clavicle (shoulder) and broken ribs. Based on interview and record review, Immediate Jeopardy (IJ) was identified on 07/11/24 at 3:15 pm to the administrator and the Director of Nursing, in person. The facility took corrective action by providing an acceptable Plan of Removal (POR) on 07/12/24 at 8:00 am. Implementation of the POR was verified onsite on 07/12/24 with ongoing trainings for staff around issues of competent nursing staff. Scope and severity was reduced to E. Plan of removal: Resident #1 was discharged to the hospital on May 16, 2024. (continued on next page)

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F 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Resident #12 was reassessed by therapy to review level of assist for transfers. Staff working with Resident #2 were educated to follow the individual care plan that was updated on how to transfer safely with regards to his current fracture. Resident #2 was also reassessed regarding his catheter bag needs and the care plan was updated. Staff working with Resident #2 were educated to follow catheter needs as directed by care plan. Identification of others having the potential to be affected: - An audit was completed on July 11, 2024 by the DON and Infection Preventionist (IP) Nurse to ensure that all residents who require peri-care are care planned for level of assistance required with peri-care. All changes will be reflected in the Kardex for CNAs. - An audit was completed on July 11, 2024 by the DON and IP Nurse to ensure that all residents with current fractures are care planned for level of assistance required due to their injury. All changes will be reflected in the Kardex for CNAs. - An audit was completed on July 11, 2024 by the DON and IP Nurse to ensure that all residents with urinary catheter bags are care planned with catheter bag change instructions. All changes will be reflected in the Kardex for CNAs. Measures / systemic changes to ensure the deficient practice does not recur: - Policies and procedures related to person centered care planning and resident rights were reviewed and utilized for education. - Education of licensed nursing staff and CNAs related to providing peri-care per individual care planned needs will be completed starting on July 11, 2024. These staff will not be allowed to work until they have received the education which will be provided prior to the start of their shift. - Education of licensed nursing staff and CNAs related to how to transfer a resident appropriately who have current fractures will be started on July 11, 2024. These staff will not be allowed to work until they have received their education and will receive education prior to the start of their shift. - Education of licensed nursing staff and CNAs related to a resident's individualized catheter bag change needs will be completed to educate to follow the resident's care plans with regards to bag change needs. Medical Director was notified of the IJ on July 11, 2024. Root cause analysis completed on July 11, 2024 and taken to QAPI. QAPI to be conducted on July 11, 2024.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35632 Based on observation, record review, and interview the facility failed to maintain proper infection prevention measures when staff failed to remove a leg catheter bag for 1 (R #1) out of 1 (R #1) resident while he lay in bed. This deficient practice of not adhering to an infection control program could likely cause a urinary tract infection. The findings are: A. Record review of the medical record face sheet for R #1 revealed he was admitted on [DATE]. He was admitted with the following diagnoses: - Dementia (symptoms affecting memory, thinking and social abilities severely enough to interfere with your daily life) - Difficulty walking, - Communication deficit, - Intracerebral hemmorrhage (a brain bleed and a type of stroke. It causes blood to pool between the brain and skull and prevents oxygen from reaching the brain. It is life-threatening), - Type II diabetes (the body does not use insulin properly), - Parkinson's disease (a progressive disorder that affects the nervous system and the parts of the body controlled by the nerves) - Neuromuscular dysfuntion of bladder (a problem in the brain, spinal cord, or central nervous system which creates a loss of bladder control). - This is not an all inclusive list. B. Record review of the physician orders for R #1 indicated orders to change catheter bag as needed for infection, obstruction, or when the closed system is compromised. Keep catheter placed below the level of the bladder. Start date: 06/13/24. C. On 07/09/24 at 5:18 pm, during an interview with R #1's Power of Attorney/Family Member, she stated she saw numerous recordings from a video camera in R #1's room of staff putting the catheter leg bag on the resident. The POA stated staff came and put the leg bag on him early in the morning. She stated R #1 did not get out of bed for hours, so he lay there with the leg bag at the same height as the catheter. The POA stated the resident's catheter leg bag must be below the catheter, so it drained into the leg bag. She said if the leg bag was level with the catheter then it will drain back into his bladder and cause an infection. D. Record review of a video from the video camera in R #1's room indicated the following: - On 06/02/24 at 5:54 am, the resident transferred from his bed to the reclining chair and had on his catheter leg bag. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	325103	A. Building B. Wing	07/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Life Care Center of Farmington	1101 West Murray Drive Farmington, NM 87401

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- On 06/19/24 at 4:42 am, a Nurse (N) #9 placed a catheter leg bag on R #1. The resident lay in bed and slept. R #1 did not get out of bed at this time. - On 06/19/24 at 8:35 am, R #1 lay in bed and had on his catheter leg bag. E. On 07/11/24 at 1:42 pm, during an interview with CNA #2, she stated there were two nights last week, sometime between 07/01/24 and 07/07/24, when R #1 had his catheter leg bag on while he was asleep in bed. She stated she did not think staff took it off him the day before. She stated that it needs to be changed so it doesn't cause an infection. F. On 07/11/24 at 3:30 pm the Director of Nursing (DON) stated if staff did not change R #1's catheter leg bag when the resident lay in bed, then it could cause the urine to back up into his bladder and cause a urinary tract infection.