STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	325104	A. Building B. Wing	08/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The NM Behavioral Health Institute at Las Vegas	3695 Hot Springs Boulevard Las Vegas, NM 87701

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 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. 34439 Based on record review and interview, the facility failed to prevent abuse for 1 (R #79) of 1 (R #79) resident reviewed when the facility staff failed to recognize the difference between horseplay and unwanted touching and harassment between a staff and resident. This deficient practice likely resulted in R #79 increase of isolation and fear of further abuse. The findings are: A. On 08/19/24 at 2:47 pm, during an interview with R #79, she stated. One of the activities persons kicked me in the ass (buttocks). They (staff) thought she was messing around. I did not think she was messing around, she kicked me. That's not funny. They sent her home for a couple of days. I felt bad because she [Activities Assistant (AA) #1] might have a ton of bills to pay or whatever. This happened on August first. I told (name of Registered Nurse #1). After that I kind of just stayed in my room because I didn't want to see her [AA #1] or do activities when she is there. She might do it again. I don't want to cause trouble and they will make me leave here (facility). R #79 further stated that she has participated less in the activity program and feels that AA #1 is upset with her and does not talk to her anymore. B. Record review of camera footage dated 08/01/24 revealed the following: - At 11:36:04 am, R #79 walked down the hallway, headed to the dining room. - At 11:36:09 am, R #79 turned to her right side, Agency Tech (T) #1 talked to R #79. Licensed Practical Nurse (LPN) #1 was at the medication cart, AA #1 stood next to the medication cart and Tech (T) #1 sat on a short bench in the hallway where R #79 walked. - At 11:36:12 am, R #79 stopped in the hallway in front of LPN #1, T #1 AT #1 and AA #1 when AA #1 approached R #79 and kicked R #79 in the backside. -At 11:36:14 am, R #79 turned around and looked at AA #1 and R #79 rubbed her left buttock with her left hand. - At 11:36:18 am, AA #1 kicked towards R #79 a second time, R #79 reached down to try and catch AA #1's leg. (continued on next page)

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

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Actual harm Residents Affected - Few	-At 11:36:20 am, R #79 pointed to AA #1 as AA #1 approached R #79 and hugged her. R #79 held her left arm between herself and AA #1. AA #1 continued to hug her and R #79 pats her on the back with her right arm and appeared to push AA #1 away. AA #1 and R #79 proceed to walk down the hallway towards the dining room. -At 11:36:31 am, AA #1 patted R #79 on the left buttock, R #79 steps back and grabbed AA #1 by the arm, picked up her right foot and kicked towards AA #1 on her right leg. AA #1 kicked towards R #79. R #79 moved back against the wall and proceeds to put her walker between herself and AA #1. AA #1 shook R #79's walker while R #79 was holding onto the walker. LPN #1, T #1 and AT #1 all appeared to watch the incident down the hallway. -At 11:37:18 am, R #79 put her walker in the entryway of the dining room, AA #1 took the walker, shuffled a short distance with the walker and then returned the walker and proceeded to walk down the hallway away from the dining room. R #79 remained in the dining room. C. On 08/21/24 at 4:19 pm, during an interview with AA #1, she stated, she was familiar with R #79, and they liked to joke and horseplay. Regarding the incident on 08/01/24, she stated that R #79 was on her way to the dining room and she was playing around with R #79 and did not believe that she had kicked R #79. AA #1 stated she was just playing around with R #79 and did not feel that she had hurt her in any way. Since the incident she has been told that she is not to interact with R #79 alone and if she needs to go to R #79's room she is to take another staff with her and she is not to approach her other then to invite her to an activity. AA #1 also stated that Registered Nurse (RN) #1 was told by R #79 about the incident. AA #1 was heading out for the day and did not return for several days. An investigation was conducted and then she was told she could return to work. D. On 08/22/24 at 10:19 am during an interview with AT #1, she stated that she was present during the incident between AA #1 and R #79. She did witness AA #1 tap the side of R #79's thigh. R #79 stated to AA #1 that she was too old to box. AT #1 also stated that they (AA#1) do horseplay. She further stated, I do not believe staff should kick residents in anyway. I did see the whole thing along with [Name of LPN #1] and [Name of T #1]. I did think it was wrong for her to play around like that. I think she [AA #1] took things a little too far. I know now [Name of R #79] stays in her room more. I did notice a change in [name of R #79] when she hears [name of AA #1]'s voice, and she will go into her room and does not come out. AT #1 stated that R #79 will go to activities when AA #1 is not here. AT #1 stated that she did not say anything [report the incident] because the nurse was there and she [nurse] had not done anything about it. E. On 08/22/24 at 10:59 am, during an interview with RN #1, she stated, the incident had been reported to her by R #79 on 08/03/24 and she thought it could be considered mistreatment/abuse and she reported it to the Standards and Compliance department at the facility, to Adult Protective Services, and the Health Care Authority on 08/03/24. RN #1 further stated, she had to prioritize R #79's safety by removing the staff from the facility. RN #1 also stated she had interviewed AA #1 and she told her that they [AA #1 and R #79] were playing. R #79 revealed to RN #1 that AA #1 had kicked her on the buttocks. RN #1 stated there is a boundary and it is not a good idea to play with a resident in that manner. RN #1 had noticed that she (R #79) is a little more paranoid and she will make comments about it (kicking incident between R #79 and AA #1). RN #1 stated. I do not think it is acceptable behavior to kick a resident. If I saw something like that happen, I would intervene and I would let the staff know it is not appropriate. Residents are to be treated with respect and dignity. (continued on next page)

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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 0600 Level of Harm - Actual harm Residents Affected - Few	F. On 08/22/24 at 11:29 am, during an interview with T #1, she stated that during the time of the incident on 08/01/24, she was waiting for lunch to start, and R #79 was headed to lunch. AA #1 was teasing R #79 and then AA #1 kicked R #79 on the buttocks. There were other staff there that saw AA #1 kick R #79 and they [staff witnesses] all thought they were just playing, no one intervened. I do not think that kicking a resident is ok. It was not a hard kick. I think it is inappropriate, but not abusive. T #1 further stated that she has noticed changes in R #79 and she is more anxious, and she is quieter since the incident. T #1 further stated that she did not report it because she thought they were just playing around. G. On 08/22/24 at 11:45 am, during an interview with the Director of Nursing (DON), she stated she was aware of the incident between AA #1, and R #79 and her understanding was that the investigation confirmed that they were horseplaying however kicking a resident is not acceptable. DON was not part of the investigation. DON further stated that after reviewing the video footage she would consider the actions of AA #1 to be abuse. DON felt that these actions should have been reported as abuse. H. On 08/22/24 at 12:02 pm, during an interview with Activity Director (AD). He stated, he was aware of the incident between AA #1 and R #79. He had spoken with AA #1 and it was determined that it was horseplay. AA #1 was trained on boundaries following the incident. He stated that a kick is overboard and could border on abuse and a playful kick is excessive and should not happen. AD stated he did not review the video but standards and compliance had determined it was horseplay. I. On 08/22/24 at 3:31 pm, during an interview with Interim Administrator, he stated, that after viewing the video footage he did believe that it was abuse and the investigation was inappropriate and that kicking a resident is never acceptable. Administrator stated he was not involved in the investigation because standards and compliance are the ones that do the investigations. He was aware of the incident but was dependent on the outcome from standards and compliance. J. On 08/23/24 at 9:35 am, during an interview with Licensed Practical Nurse (LPN) #1, she stated, she was passing medications at the time of the incident. R #79 was on her way to the dining room and the staff were joking around with R #79. LPN #1 does not recall seeing AA #1 kick R #79. She stated that kicking a resident is not acceptable and if she would have seen it [AA #1 kick R #79], she would have intervened.

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 34439 Based on record review and interview, the staff failed to immediately report a witnessed incident of abuse to a supervisor and the facility failed to report an incident of abuse to the state survey agency within 2 hours for 1 (R #79) of 1 (R# 79) resident reviewed for incidents/accidents. If the facility fails to report incidents of abuse to the State Agency, then the implementation of measures to prevent further abuse is delayed. The findings are: A. On 08/19/24 at 2:47 pm, during an interview with R #79, she stated. One of the activities persons kicked me in the ass (buttocks). They (staff) thought she was messing around. I did not think she was messing around, she kicked me. That's not funny. They sent her home for a couple of days. This happened on August first. I told (name of Registered Nurse #1). After that I kind of just stayed in my room because I didn't want to see her [AA #1] or do activities when she is there. She might do it again. I don't want to cause trouble and they will make me leave here (facility). R #79 further stated that she has participated less in the activity program and feels that AA #1 is upset with her and does not talk to her anymore. B. Record review of camera footage dated 08/01/24 revealed the following: - At 11:36:04 am, R #79 walked down the hallway, headed to the dining room. - At 11:36:09 am, R #79 turned to her right side, Agency Tech (T) #1 talked to R #79. Licensed Practical Nurse (LPN) #1 was at the medication cart, AA #1 stood next to the medication cart and Tech (T) #1 sat on a short bench in the hallway where R #79 walked. - At 11:36:12 am, R #79 stopped in the hallway in front of LPN #1, T #1 AT #1 and AA #1 when AA #1 approached R #79 and kicked R #79 in the backside. -At 11:36:14 am, R #79 turned around and looked at AA #1 and R #79 rubbed her left buttock with her left hand. - At 11:36:18 am, AA #1 kicked towards R #79 a second time, R #79 reached down to try and catch AA #1's leg. -At 11:36:20 am, R #79 pointed to AA #1 as AA #1 approached R #79 and hugged her. R #79 held her left arm between herself and AA #1. AA #1 continued to hug her and R #79 pats her on the back with her right arm and appeared to push AA #1 away. AA #1 and R #79 proceed to walk down the hallway towards the dining room. -At 11:36:31 am, AA #1 patted R #79 on the left buttock, R #79 steps back and grabbed AA #1 by the arm, picked up her right foot and kicked towards AA #1 on her right leg. AA #1 kicked towards R #79. R #79 moved back against the wall and proceeds to put her walker between herself and AA #1. AA #1 shook R #79's walker while R #79 was holding onto the walker. LPN #1, T #1 and AT #1 all appeared to watch the incident down the hallway. (continued on next page)

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-At 11:37:18 am, R #79 put her walker in the entryway of the dining room, AA #1 took the walker, shuffled a short distance with the walker and then returned the walker and proceeded to walk down the hallway away from the dining room. R #79 remained in the dining room. C. On 08/22/24 at 10:19 am during an interview with AT #1, she stated that she was present during the incident between AA #1 and R #79. She did witness AA #1 tap the side of R #79's thigh. R #79 stated to AA #1 that she was too old to box. AT #1 also stated that they (AA#1) do horseplay. She further stated, I do not believe staff should kick residents in anyway. I did see the whole thing along with [Name of LPN #1] and [Name of T #1]. I did think it was wrong for her to play around like that. I think she [AA #1] took things a little too far. I know now [Name of R #79] stays in her room more. I did notice a change in [name of R #79] when she hears [name of AA #1]'s voice, and she will go into her room and does not come out. AT #1 stated that R #79 will go to activities when AA #1 is not here. AT #1 stated that she did not say anything [report the incident] because the nurse was there and she [nurse] had not done anything about it. AT #1 confirmed that she never checked on the resident after the incident. D. On 08/22/24 at 10:59 am, during an interview with RN #1, she stated, the incident had been reported to her by R #79 on 08/03/24 and she thought it could be considered mistreatment/abuse and she reported it to the Standards and Compliance department at the facility, to Adult Protective Services, and the Health Care Authority on 08/03/24. RN #1 further stated, she had to prioritize R #79's safety by removing the staff from the facility. RN #1 also stated she had interviewed AA #1 and AA #1; they both told her that they were playing. R #79 revealed to RN #1 that AA #1 had kicked her on the buttocks. RN #1 stated there is a boundary and it is not a good idea to play with a resident in that manner. RN #1 had noticed that she (R #79) is a little more paranoid and she will make comments about it (kicking incident between R #79 and AA #1). RN #1 stated. I do not think it is acceptable behavior to kick a resident. If I saw something like that happen, I would intervene and I would let the staff know it is not appropriate. Residents are to be treated with respect and dignity. E. On 08/22/24 at 11:29 am, during an interview with T #1, she stated that during the time of the incident on 08/01/24, she was waiting for lunch to start, and R #79 was headed to lunch. AA #1 was teasing R #79 and then AA #1 kicked R #79 on the buttocks. There were other staff there that saw AA #1 kick R #79 and they [staff witnesses] all thought they were just playing, no one intervened. I do not think that kicking a resident is ok. It was not a hard kick. I think it is inappropriate, but not abusive. T #1 further stated that she has noticed changes in R #79 and she is more anxious, and she is quieter since the incident. T #1 further stated that she did not report it because she thought they were just playing around. T #1 confirmed that she never checked on the resident to confirm how she felt about the interaction. F. On 08/23/24 at 9:35 am, during an interview with Licensed Practical Nurse (LPN) #1, she stated, she was passing medications at the time of the incident [on 08/01/24]. R #79 was on her way to the dining room and the staff were joking around with R #79. LPN #1 does not recall seeing AA #1 kick R #79. She stated that kicking a resident is not acceptable and if she would have seen it [AA #1 kick R #79], she would have intervened. G. Record review of the facility self report revealed that the incident between AA #1 and R #79 was reported to the State Agency on 08/03/24.

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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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41988 Based on record review and interview, the facility failed to ensure residents received the necessary treatment and services to prevent the development and worsening of pressure wounds (also called a pressure injury; skin damage which results from unrelieved pressure on the body) for 1 (R #16) of 1 (R #16) residents reviewed when staff failed to update wound care treatment orders according to R #16's care plan and in relation to R #16's pressure ulcer becoming worse. This deficient practice is also likely to lead to residents developing more/other pressure ulcers and wounds worsening. The findings are: A. Record review of R #16's face sheet revealed R #16 was admitted into the facility on [DATE]. B. Record review of R #16's care plan dated 07/09/24 revealed, Focus: Impaired skin integrity related to Stage II [2] pressure injury (level of skin damage which results from unrelieved pressure on the body) to coccyx (tailbone). Interventions: If pressure injury is not improving within 2 weeks of using current treatment, reassess and notify medical provider for a change of treatment. C. Record review of R #16's coccyx pressure ulcer assessment dated [DATE] through 08/23/24 revealed the following: 1. 07/05/24: Length: 3 cm (centimeters), Width: 1 cm. 2. 07/08/24: Length: 3 cm, Width: 1 cm. 3. 07/10/24: Length: 3 cm, Width: 1 cm. 4. 07/12/24: Length: 3 cm, Width: 1 cm. 5. 07/15/24: Length: 3 cm, Width: 1 cm. 6. 07/17/24: Length: 3 cm, Width: 1 cm. 7. 07/19/24: Length: 3 cm, Width: 1 cm. 8. 07/22/24: Length: 3 cm, Width: 1 cm. 9. 07/24/24: Length: 3 cm, Width: 1 cm. 10. 07/26/24: Length: 3 cm, Width: 1 cm. 11. 07/29/24: Length: 3 cm, Width: 1 cm. Wounds showing no signs of improvement. 12. 07/31/24: Length: 4 cm, Width: 1 cm. (continued on next page)

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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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	13. 08/02/24: Length: 4 cm, Width: 1 cm. 14. 08/05/24: Length: 4 cm, Width: 1 cm. 15. 08/07/24: Length: 4 cm, Width: 1 cm. 16. 08/09/24: Length: 4 cm, Width: 1 cm. 17. 08/12/24: Length: 4 cm, Width: 1 cm. 18. 08/14/24: Length: 4 cm, Width: 1 cm. 19. 08/16/24: Length: 4 cm, Width: 1 cm. 20. 08/19/24: Length: 4 cm, Width: 1 cm. 21. 08/21/24: Length: 2.5 cm, Width: 0.5 cm. D. Record review of R #16's Medication Administration Record (MAR) dated 07/01/24 through 07/31/24 revealed the following medications/treatments used for R #16's coccyx pressure ulcer: 1. Apply skin protectant, cover with 2x2 (2 by 2) gauze and transparent tape twice a day and as needed-completed twice a day, every day from 07/01/24 through 07/10/24. 2. Apply skin protectant, cover with 2x2 gauze and transparent tape daily- completed once a day, every day from 07/11/24 through 07/31/24. E. On 08/23/24 at 10:44 am, during an interview with Licensed Practical Nurse (LPN) #2, she stated R #16's coccyx pressure ulcer was a stage 2 and was not getting better until recently. LPN #2 confirmed R #16's pressure ulcer treatment and care had not changed since R #16 developed on 06/28/24 the pressure ulcer (Apply skin protectant, cove with 2x2 gauze and transparent tape daily) . F. On 08/23/24 at 1:03 pm during an interview with the Director of Nursing (DON), she stated she would expect R #16's pressure ulcer treatment to change according to her care plan which stated if R #16's pressure ulcer did not improve within two weeks treatment would change. DON confirmed R #16's pressure ulcer treatments changed, but not within the two week timeframe as expected. Treatment was changed from BID (twice a day) to daily.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 41988 Based on observation, record review, and interview, the facility failed to ensure that 1 (R #16) of 1 (R #16) residents reviewed was free from accidents and hazards. Facility was using a call light attached to R #16's clothing to alert staff when resident attempts to transfer on her own. Call light would detach from the wall and ring and staff would be alerted that resident was attempting to transfer self. This deficient practice is likely to put residents at risk of unsafe situations. The findings are: A. Record review of R #16's face sheet revealed R #16 was admitted into the facility on [DATE]. B. Record review of R #16's nursing progress notes dated 06/09/24 through 06/10/24 revealed the following: 1. 06/09/24: R #16 was found on the floor next to her bed by staff. R #16 was attempting to use the restroom on her own prior to fall and told staff her left hip hurt badly. R #16 was transported to the emergency room (ER). 2. 06/10/24: R #16 was diagnosed with two fractures in the ER and returned to the facility. C. On 08/20/24 at 10:13 am during an observation of R #16's room, R #16 sat in a wheelchair with the room call light attached to her left shoulder shirt. D. Record review of R #16's care plan dated 07/09/24 revealed R #16 was at risk for falls. R #16's care plan interventions stated, I am able to use the call bell. It will be kept within my reach. Staff will educate me on using the call bell with transfers. E. On 08/23/24 at 9:42 am during an interview with Certified Nursing Assistant (CNA) #6, she stated R #16 has become less independent and is prone to falls. CNA #6 also stated the staff attaches R #16's call light onto her clothing because when R #16 attempts to self transfer, the call light will disconnect from the wall (since it's attached to her body), which will alert staff. F. On 08/23/24 at 10:47 am during an interview with Licensed Practical Nurse (LPN) #2, she stated R #16 sustained a left hip fracture after her most recent fall on 06/09/24. LPN #2 also stated the nursing staff will attach R #16's call light to her clothing, so staff will be alerted if R #16 attempts to self transfer. G. On 08/23/24 at 11:04 am during an observation of R #16's room, R #16 laid in bed with the call light attached to right shoulder. H. On 08/23/24 at 12:59 pm during an interview with the Director of Nursing (DON), she stated the expectation is staff can clip R #16's call light to blanket or something like that, but not to R #16's clothing. DON confirmed the way the staff is currently using the call light for R #16 is considered a form of a restraint and should not be happening.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 38450 Based on observation, interviews, and record review, the facility failed to have recipes for all menu items and to ensure staff followed nutritionally calculated recipes for pureed diets. This failure had the potential for food not to meet the nutritional requirements of all residents who ate pureed foods. The findings are: A. On 08/20/24 at 8:55 am, during an interview, the Supervisor stated the menu for the resident's lunch was pork enchiladas, mixed vegetables, beans, and fruit. She stated the alternative was egg salad sandwich, and residents with a pureed diet were having pureed carrots instead of pureed mixed vegetables. B. Observation on 08/20/24 at 8:56 am revealed the Supervisor prepared pureed enchiladas for the residents' lunch service. She placed six corn tortillas (six inch), six servings of enchilada mixture, and scooped an unmeasured amount of thickening powder into a food processor. The Supervisor pureed the mixture to a pudding consistency. C. On 08/20/24 at 8:58 am during an interview, the Supervisor stated the scoop for the thickening powder was equal to one cup. She stated she put 1/2 cup (c) of thickening powder into the enchilada puree. D. Record review of the facility's recipes revealed a recipe for green chicken or pork enchiladas for regular diets. Further review revealed the records did not contain a recipe for green chicken or pork enchiladas for pureed diets. E. Observation on 08/20/24 at 9:00 am, revealed pureed carrots in bowls in the warmer for the residents' lunch service. Taste test of the pureed carrots revealed the mixture tasted flavorless. F. On 08/20/24 at 9:02 am during an interview, the Supervisor stated the puree carrots was made of carrots and thickening powder. G. Record review of the facility's recipes revealed a recipe for pureed carrots with the following instructions: - Recipe for 240 servings. - Ingredients: fresh steamed carrots, thickener, hot water, vegetable base, salted and melted butter. - Process carrots to a fine consistency. - Add thickener, vegetable base mixed with hot water, and butter. - Process until smooth. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	H. Observation on 08/20/24 at 9:22 am revealed the [NAME] prepared pureed carrot cake for the residents' meal. She placed 12 slices of carrot cake, 12 cups of water, and two cups of a thickening powder into a food processor. She pureed the mixture to a smooth consistency. Taste test showed the mixture tasted watery. The [NAME] placed the mixture into styrofoam bowls and topped with an icing mixture. I. On 08/20/24 at 9:32 am, the [NAME] stated she had recipes in her phone and in a binder. She stated she made the pureed carrot cake in the past, so she did not refer to the recipe. J. Record review of the facility's recipes revealed the facility did not have a recipe for pureed carrot cake. K. Observation on 08/20/24 at 9:45 am revealed the Supervisor prepared pureed beans for the residents' lunch service. She placed 24 ounces (oz) of beans and broth mixture and scooped an unmeasured amount of thickening powder into a food processor. She pureed the mixture to a smooth consistency. The Supervisor added an unmeasured amount of tap water to the mixture and continued to puree to a smooth consistency. L. On 08/20/24 at 9:50 am during an interview, the Supervisor stated she added 3/4 c of thickening powder to the beans and 1/2 c of water. The Supervisor stated she knew how to prepare the pureed food because she worked at the facility for a long time. She stated, she measured all the ingredients, and there was a sheet posted in the kitchen regarding the consistency of each diet type. The Supervisor stated there were recipes for the menu items, and there was a recipe for everything. M. Record review of the facility's recipes revealed a recipe for pureed beans with the following instructions: - Recipe for 240 servings. - Ingredients: pinto beans cooked with onions, chopped garlic cloves, bay leaf, salt, oregano. - Place the cooked beans in food processor and process fine and until the texture is very smooth. - Scrape down the sides of the bowl and repeat the process. N. On 08/20/24 at 10:25 during an interview, the Director of Food Services stated, she was responsible for the residents' meals, the menus, and the recipes. She stated the Dieticians created the menus and approved the recipes based on an analysis of the residents' needs. The Director stated the residents asked for more authentic New Mexican food, and the menu did not have those items. She stated she created the recipe for the green chicken or pork enchiladas to meet the residents' requests. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	O. On 08/20/24 at 10:50 am during an interview with the Director of General Services, the Director of Food Services, and the Dieticians, and the Supervisor, Dietician 1 and Dietician 2 stated they were responsible to develop and analyze the menus. They stated, they made the menus from scratch in order to take into account what the residents wanted to eat. They stated they also approved the recipes, but there was not a recipe for all food items. The Dieticians stated staff cooked the way they were used to, because the most important part of the recipe was the meat. They stated the meat was pre-portioned, so all cooks used the same amount of meat in their recipe. The Dieticians stated cooks should use the recipe closest to what they were preparing, even if it was not for the exact food item on the menu. The Dieticians reviewed the green chicken or pork enchilada recipe. They stated they had not seen and did not approve the enchilada recipe. The Dietician stated it was expected all food items on the menu had a recipe for staff to follow and that they review and approve all recipes served to the residents. They stated this was important for consistency across all cooks and preparation, for nutritional values, and for flavor. The Dieticians stated there was not a recipe for the carrot cake puree, but it was expected staff would use milk instead of water. They stated the milk had more nutritional value and flavor. The Dieticians stated it was expected staff would use thickening powder sparingly, because it did not have any nutritional value. They stated staff should not use thickening powder by the cup. They stated the Supervisor did not need to add thickening powder to the beans. The Dieticians stated they performed competency audits of the dietary staff, but the audits did not include an observation of the preparation of pureed foods.

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47031 Based on record review, and interview, the facility failed to provide food that accommodated resident preferences for 2 (R #9 and R #69) of 2 (R #9 and R #69) residents reviewed for food preferences. This deficient practice is likely to result in weight loss due to the residents not eating or an allergic reaction to the food being served to the residents. The findings are: A. Record review of R #69's face sheet revealed, R #69 was admitted into the facility on [DATE]. B. Record review of R #69's care plan dated 7/10/2024, revealed the following: -Focus: Diet is Therapeutic Diet.(diet modified to fit the nutrition need of a resident) -Interventions: Provide diet as ordered and honor all food preferences. C. Record review of facility incident report form dated 03/20/24, R #69 requested a chicken sandwich (choice #2) for dinner. R #69 did not receive chicken sandwich as ordered because the dietary had only sent three chicken sandwiches for the unit. D. Record review of facility incident report form dated 03/20/24, revealed there were only three chicken sandwiches sent to the unit for 14 residents as an alternate meal and regular menu items were sent for all residents. E. Record review of R #9's facesheet revealed R #9 was admitted to the facility on [DATE]. F. Record review of R #9's nutritional assessment review dated 06/30/2024 revealed Regular LCS (Low Concentrated Sweets), bland diet, no Chile, Glucerna (nutritional supplement) with lunch and milk with all meals. HS (evening) snack. Honor all food preferences. G. Record review of facility incident report form dated 03/20/24 stated there were only three chicken sandwiches sent to the unit for 14 residents as an alternate meal and R #9 was not able to get one. H. On 08/22/2024, during an interview with Dietary Manager, she stated only a set amount of alternate food is sent to the units. If a resident request an alternate food, and there were not enough food then the can call and request a alternate meal. The resident will have to wait until service of meals are done and then they would accommodate the residnets' alternative request which could take a considerable amount of time to wait.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 38450 Based on observation, interviews, and record review, the facility failed to maintain the kitchen in a sanitary manner when staff failed to: - Perform hand hygiene and to change gloves as often as necessary to avoid cross contamination, - Store open food protected and with labels and dates to prevent cross contamination and outdated usage, - Utilize hair restraints and beard guards in a manner which restrained all hair while in the kitchen, - Use the sanitizing solution according to manufacturer's instructions, - Protect clean disposable wares (includes dishware, drinkware, and flatware such as spoons, forks, and knives) to prevent contamination, These failures had the potential to result in cross contamination and foodborne which could affect all residents who ate food from the kitchens. The findings are: Handwashing and Glove Use A. Record review of the facility's Sanitation and Infection Control, Hand Hygiene policy, dated January 2014, revealed staff directed to wash hands with soap and water at the following times: - Before handling food or clean utensils, dishes, equipment, - Before putting on gloves, - After touching hair, skin, beard, or clothing, - After handling soiled silverware, - After handling garbage, - After removing gloves, - After any other activity that may contaminate the hands. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	B. Observation on 08/20/24 at 12:15 pm, of the kitchen located on Unit #1 revealed Server 1 wore gloves and entered the kitchen. The Server touched the door, the trash can, and dirty dishes. The Server took clean dishes out of the dishwasher and put them away. The Server did not remove his gloves and did not perform hand hygiene when he moved from dirty tasks (touching dirty dishes, cleaning the kitchen, taking out trash, and similar) to clean task (touching clean dishes, preparing food, and similar). At 12:26 pm, Server 1 touched dietary cards and dirty dishes. He took the dirty dishes to the three-compartment sink (a sink with three sections to wash, rinse, and sanitize) and touched the hose with dish detergent to fill a tub of dishes with soapy water. He took the tubs to the dirty side of the dishwashing area, removed a clean pitcher from the dishwasher, and placed it on the storage shelf. Server 1 did not remove his gloves and did not perform hand hygiene when moving from dirty dishes to clean dishes. The Server placed the same gloved hand on a trash can, with part of his fingers inside the can, to move it across the floor. He removed the trash bag of waste from the can, and he placed a new trash bag in the can. The Server removed clean dishes from the dishwasher and put them away. The Server did not remove his gloves and did not perform hand washing after touching the trash can. C. On 08/21/24 at 8:40 am, during an interview, the Supervisor stated the facility had a policy for glove use and handwashing, and staff have been trained on the policy. She stated staff should hand wash before putting on gloves and after removing the gloves. She stated staff should also hand wash every time they entered the kitchen, when they moved from a dirty task to a clean task, and after they used the restroom, took a break, or touched their face or body. She stated staff should change their gloves when soiled, between processes, and after touching something that was not food related. The Supervisor stated staff should not treat their gloved hands like their bare hands. D. Observation on 08/21/24 at 11:25 am of the kitchen located on Unit #2 revealed Server 2 wore gloves and prepared for the resident's lunch service. The Server threw a piece of paper into the trash can and touched the lid. The Server continued to touch the steam table, the door to the dining room, a piece of paper, the refrigerator door handle, serving containers of butter and supplement drinks, and drink pitchers. The Server did not change her gloves or wash her hands after touching the trash can and before touching the steam table and food related items. At 11:34 am, the Server removed her gloves and performed hand washing. Server 1 pressed the buttons to open the partition between the kitchen and the dining room. She put on new gloves. The Server touched the resident food trays, dietary cards, the thermometer, food containers. The Server touched the resident plates, serving utensils, refrigerator doors, and bread slices with her gloved hands. She pulled up the sleeve on her right arm using her gloved left hand. The Server touched resident bowls with her gloved thumb on the food surface area. The Server did not wash her hands after touching the divider buttons and before putting on gloves. The Server did not change her gloves and perform hand washing after she touched the refrigerator doors and her sleeve and before she touched food and food related items. E. On 08/21/24 at 12:15 pm, during an interview, the Director of General Services stated the Supervisors were responsible to ensure the kitchen was maintained in a clean, orderly, and sanitary manner. She stated it was expected staff would perform handwashing when they moved from a dirty task to a clean task. She stated staff should wear gloves when handling ready to eat food, like bread. She stated staff should wash their hands before they put on and after they removed their gloves. The Director stated staff should not treat their gloved hands like their bare hands. Unprotected, Unlabeled, and Undated Open Food Items (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	F. Record review of the facility's Production, Purchasing, Storage: Food and Supply Storage Procedures policy, dated January 2014, revealed staff directed to cover, label, and date unused portions and open packages. G. Observation on 08/19/24 at 12:20 pm, of the dry storage area, revealed two, 25 pound (lb) bags of pinto beans open to air. H. Observation on 08/20/24 at 8:52 am, of the walk-in refrigerator Morning Box, revealed the following: - One package of sliced ham open to air, - One, 16 ounces (oz) container of beef base opened and undated, - One, 16 oz container of vegetable base opened and undated. I. On 08/20/24 at 8:53 am, during an interview, the Director of General Services stated opened food should be labeled, dated, and sealed. She said it was expected staff would have wrapped the opened ham slices with saran wrap to protect it from the air. She stated she and the Supervisors walked through the walk-ins every day and looked for items that were not in compliance. The Director of General Services stated she was not aware the unlabeled, undated, and unprotected food items were in the walk-in. J. Observation on 08/20/24 at 8:28 pm of the dry storage area, revealed one 5 lb bag of powdered cocoa loosely rolled, opened, and exposed to air. K. On 08/20/24 at 8:30 am, during an interview, the Stocker stated, she was responsible to ensure the dry storage area was maintained in an orderly and sanitary manner. She stated she checked the dry pantry every day to ensure items were stored correctly, labeled, dated, and protected. The Stocker stated staff used the cocoa for breakfast. She stated they forgot to secure the cocoa bag with the plastic tabs when they rolled the top closed. The Stocker stated staff should have ensured the bag remained rolled closed to prevent exposure to air. L. On 08/21/24 at 8:40 am, during an interview, the Supervisor stated the facility had a policy on food storage, and staff have been trained on the policy. She stated it was expected for staff to label and date open food with the date the food was opened. She stated food should be securely protected from air to prevent cross contamination. Hairnets and [NAME] Guards M. On 08/20/24 at 10:50 am during an interview with the Director of General Services, the Director of Food Services, and the Dieticians, Dietician 1 and Dietician 2 stated they were responsible to perform audits of kitchen staff, and they performed the audits twice a week. The Dieticians stated they completed a form for each audit and gave the form to the Director of General Services to address any issues with the dietary staff. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	N. Observation on 08/21/24 at 11:07 am revealed Server 1 in the kitchen Unit #1 took the food temperatures in preparation for the resident's lunch service. The Server wore a beard guard, but the beard guard did not cover the Server's mustache. The Server's mustache measured approximately 1/4 inch () to 1 in length. O. Observation on 08/21/24 at 11:25 am revealed Server 2 in the kitchen Unit #2 prepared food items for the resident's lunch service. The Server wore a hairnet, but the hairnet did not cover all the Server's hair. The Server's hair hung loosely around her face and measured approximately 2 1/2 in length. Further observation revealed two Dieticians stood in the kitchen and observed Server 2, but the Dieticians did not coach the Server to cover all her hair with the hairnet while working with the residents' food. P. On 08/21/24 at 12:15 pm, during an interview, the Director of General Services stated the Supervisors were responsible to ensure the kitchen was maintained in a clean, orderly, and sanitary manner. She stated the facility had a policy on hair nets, and staff are trained on the policy. She stated all staff must wear hairnets at all times when they enter the kitchen, and they are to wear beard guards, as needed, at all times in the kitchen. She stated they must wear hairnets and beard guards regardless of the length of their hair. The Director stated the hairnets and beard guards should cover all the hair. Dishes Not Sanitized According to Manufacturer's Instructions Q. Review of the facility's Sanitation and Infection Control, Sanitizing Food Contact Surfaces policy, dated January 2014, revealed staff directed to immerse items in the sanitizing solution for a minimum of 60 seconds when washing dishes in the pot sink (three-compartment sink). R. Review of the manufacturer's instructions for the sanitizing solution used by the facility in the three-compartment sink revealed the product could be used to clean and sanitize hard, non-porous surfaces of equipment. To sanitize, allow surfaces to remain wet for at least 60 seconds. S. Observation on 08/21/24 at 8:05 am revealed the Dishwasher washed pots and pans in the three-compartment sink. The Dishwasher washed a pan in the soapy water, placed the pan in the clean rinse water, dipped the pan in the sanitizing solution, and placed the pan on the rack to air dry. The Dishwasher washed a plastic container in the soapy water, rinsed it in the clean water, dipped it the sanitizing solution, and placed it on the rack to air dry. The Dishwasher did not submerge the pan or the plastic container in the sanitizing solution for one minute, per the manufacturer's instructions. At 8:15 am, the Supervisor watched the Dishwasher dip the pots and pans into the sanitizing solution instead of submerging the items for one minute. The Supervisor coached the Dishwasher and told her to submerge the items in the sanitizing solution for one minute. At 8:22 am, the Dishwasher washed a baking sheet in the soapy water, rinsed it in the clean water, dipped it into the sanitizing solution, and placed it on the rack to air dry. The Dishwasher did not submerge the baking sheet in the sanitizing solution for one minute, per the manufacturer's instructions. T. On 08/21/24 at 8:25 am during an interview, the Dishwasher stated items should be submerged into the sanitizing solution and not just dipped. The Dishwasher stated she was not exactly sure how long the items should be in the sanitizing solution, but she thought it should be around one minute. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	U. On 08/21/24 at 8:40 am, during an interview, the Supervisor stated staff should completely submerge the dishes in the sanitizing solution for one minute when they washed dishes in the three-compartment sink. The Supervisor stated she observed the Dishwasher failed to sanitize the dishes correctly, so she told the Dishwasher to leave the items in the sink for one minute. The Supervisor stated it was expected the Dishwasher would have followed the directions for sanitizing the equipment. She stated dipping the dishes into the sanitizing solution was not sufficient. V. On 08/21/24 at 12:15 pm, during an interview, the Director of General Services stated the Supervisors were responsible to ensure the kitchen was maintained in a clean, orderly, and sanitary manner. She stated staff should ensure dishes are completely submerged in the sanitizer solution for one minute to ensure the items were properly sanitized. Protection of Disposable Ware W. Observation on 08/20/24 at 8:31 am of the dry storage area revealed the following: - One box of plastic spoons opened and unprotected. - One box of plastic forks opened and unprotected. - One box of plastic knives opened and unprotected. - One box of disposable aluminum serving pans opened with food surface exposed and unprotected. X. Record review of the facility's Production, Purchasing, Storage: Food and Supply Storage Procedures policy, dated January 2014, revealed staff directed as follows: - Store all single-service items with food contact surfaces facing down. - After single-serve items, such as disposable plates or containers, have been opened, they must be stored inverted on clean surfaces to prevent contamination. - The policy did not address the storage of plastic wares, such as forks, spoons, and knives. Y. On 08/20/24 at 8:33 am, the Stocker stated she was responsible to ensure items in the dry storage area were stored in a sanitary manner. She stated staff got plastic ware for the residents' breakfast service. She stated it was expected the staff would cover the plastic ware after they got what they needed. The Stocker stated the disposable aluminum pans should also be protected. She stated when the items are unprotected and open to air then they are at risk of contamination by dust, flies, or other contaminants. Z. On 08/21/24 at 8:40 am, during an interview, the Supervisor stated the facility had a policy on ware storage, and the staff have been trained on the policy. She stated it was expected wares were stored in their original packaging. She stated staff should take what they needed out of the box and use the plastic to recover the items. The Supervisor stated disposable wares should not be exposed to air to prevent cross contamination. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	AA. On 08/21/24 at 12:15 pm, during an interview, the Director of General Services stated the Supervisors were responsible to ensure the kitchen was maintained in a clean, orderly, and sanitary manner. She stated it was expected disposable wares were covered and not exposed to the air and potential contaminates. She stated staff should take what they needed and cover the items. She stated the Stocker checked the storage areas daily to ensure all items were covered, but other staff were also responsible to ensure the items were covered after they got what they needed.

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F 0825 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide or get specialized rehabilitative services as required for a resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41988 Based on record review and interview, the facility failed to meet professional standards of care for 3 (R #8, #42, and #52) of 3 (R #'s #8, #42, and #52) residents reviewed by not providing restorative nursing services (a type of rehabilitation that helps residents regain or maintain their independence and physical abilities) as ordered by a physician. This deficient practice is likely to result in the resident experiencing psychosocial harm (harm to someone's mental health) and despair. The findings are: R #8: A. Record review of R #8's face sheet revealed R #8 was admitted into the facility on [DATE]. B. Record review of R #8's physician order/referral dated 07/10/24 revealed R #8 was to receive restorative nursing services weekly that focused on Upper extremity [arms] exercises that focus on range of motion (ROM). C. Record review of the facility restorative nursing program schedule dated 08/01/24 through 08/23/24 revealed R #8 was offered/provided six (6) restorative nursing sessions out eight (8) opportunities. D. On 08/19/24 at 4:21 pm during an interview with R #8, she stated that she was not offered restorative nursing services as often as she would like. E. On 08/23/24 at 12:14 pm during an interview with the Physical Therapy Assistant (PTA) #1, she stated that they try to offer R #8 restorative nursing services at least two times a week, but that doesn't always happen because PTA #1 and the other restorative staff are needed on the units instead. PTA #1 confirmed R #8 should be seen by restorative nursing services at least two times a week and that does not consistently happen. R #42: F. Record review of R #42's face sheet revealed R #42 was admitted into the facility on [DATE]. G. Record review of R #42's physician order/referral dated 08/01/24 revealed R #42 was to receive restorative nursing services weekly that focused on ambulation (the ability to walk or move about without assistance) and ROM. H. Record review of the facility restorative nursing program schedule dated 08/01/24 through 08/23/24 revealed R #42 was offered/provided one restorative nursing sessions out eight (8) opportunities. I. On 08/23/24 at 2:42 pm during an interview with PTA #1, she stated that they are supposed to help ambulate R #42, but they cannot because they do not have the staff available to do that while also taking residents to appointments and working on the units. PTA #1 confirmed R #8 had only been offered one restorative nursing service session since 08/01/24, and he should have been offered more. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	325104	A. Building B. Wing	08/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The NM Behavioral Health Institute at Las Vegas	3695 Hot Springs Boulevard Las Vegas, NM 87701

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 0825 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R #52: J. Record review of R #52's face sheet revealed R #52 was admitted into the facility on [DATE]. K. Record review of R #52's physician order/referral dated 02/27/24 revealed R #52 was to receive restorative nursing services weekly that focused on ROM. L. Record review of the facility restorative nursing program schedule dated 07/01/24 through 07/19/24 revealed R #52 was offered/provided one restorative nursing sessions out six (6) opportunities. M. Record review of the facility restorative nursing program schedule dated 08/01/24 through 08/23/24 revealed R #52 was offered/provided two (2) restorative nursing sessions out eight (8) opportunities. N. On 08/23/24 at 2:49 pm during an interview with PTA #1, she confirmed R #52 was not offered consistent restorative nursing sessions due to staffing issues and R #52 should be offered more restorative nursing sessions. O. On 08/23/24 at 3:04 pm during an interview with the Director of Nursing (DON), she stated she was not aware of restorative nursing staff not completing their treatments with the residents. DON confirmed residents that are receiving restorative nursing services should be offered/provided those multiple times per week as expected.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	325104	A. Building B. Wing	08/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The NM Behavioral Health Institute at Las Vegas	3695 Hot Springs Boulevard Las Vegas, NM 87701

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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 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. 41988 Based on record review and interview, the facility failed to ensure Certified Nurse Aides (CNAs) received the required in-service training of no less than 12 hours per year for 2 (CNAs #1 and #2) of 5 (CNAs #1, #2, #3, #4, and #5) CNAs randomly reviewed for required in-service training. This deficient practice is likely to result in the nurses aides not receiving the necessary training to meet the care needs of the residents. The findings are: CNA #1: A. Record review of the facility staffing list revealed CNA #1 was hired on 04/30/22. B. Record review of CNA #1's annual required in-service training revealed CNA #1 had only completed 8 out of 12 hours of required training by hire date. C. Record review of the facility staffing schedule dated 06/23/24 through 08/23/24 revealed CNA #1 worked 124 total shift hours during that timeframe. CNA #2: D. Record review of the facility staffing list revealed CNA #2 was hired on 06/17/17. E. Record review of CNA #2's annual required in-service training revealed CNA #2 had only completed 10 out of 12 hours of required training by hire date. F. Record review of the facility staffing schedule dated 06/23/24 through 08/23/24 revealed CNA #2 worked 317 total shift hours during that timeframe. G. On 08/22/24 at 4:08 pm during an interview with the Director of Nursing (DON), she confirmed CNAs #1 and #2 did not have at least 12 hours of completed in-service training's and should have. DON stated CNAs should not be working with residents without the completed required training's.