| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 325111 | A. Building<br>B. Wing | 01/30/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| The Village at Northrise - Desert Willow I | 2884 North Road Runner Parkway<br>Las Cruces, NM 88011 |

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| F 0609<br><br>Level of Harm - Potential for minimal harm<br><br>Residents Affected - Many | Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.<br><br>49313<br><br>Based on record review and interview the facility failed to report the results of all of the investigations of alleged medication diversion (the transfer of any legally prescribed controlled substance from the individual for whom it was prescribed to another person for any illicit use) and injuries of unknown origin within five days of the incident to the State Agency. This deficient practice has the potential to affect all 27 residents in the facility. If the facility fails to report the results of the investigations to the State Agency within five days, then corrective action may not be taken and medications may not be available to residents during an emergency and/or residents may suffer serious bodily injury due to injuries of unknown origin. The findings are:<br><br>Injury of Unknown Origin<br><br>R #200<br><br>A. Record review of the initial incident report, dated 08/20/24, revealed the following:<br><br>1. R #200 was sent to the emergency room due to a nose bleed (no date).<br><br>2. R #200 was found to have rib fractures and a compression fracture of her Thoracic 10 vertebrae (bone in the back).<br><br>3. Family was questioned regarding the cause of R #200's fractures.<br><br>4. Medical records were obtained to try to find the cause of R #200's fractures.<br><br>5. No cause was identified.<br><br>B. Record review of the facility's 5 day report, no date (due 08/25/24), revealed the following:<br><br>1. R #200 had a fall a week prior (no date) to going to the hospital (this was prior to her admission at the facility).<br><br>2. The record did not contain documentation that the follow-up report was submitted to the State Agency within five days of the incident.<br><br>(continued on next page) |



| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| F 0609<br><br>Level of Harm - Potential for minimal harm<br><br>Residents Affected - Many | Medication Diversion<br><br>C. Record review of the initial incident report, dated 07/26/24, revealed the following:<br><br>1. The incident report was being submitted due to missing narcotics.<br><br>2. The date of the incident was on 07/17/24.<br><br>D. Record review of the facility's 5 day report, no date (due 07/31/24) revealed the following:<br><br>1. The medication count on the Emergency Kit (kit designed to help nursing facilities provide medication to their residents during emergency situations) was inaccurate (no date specified).<br><br>2. The facility developed new interventions to ensure the Emergency Kit was secure and cannot be accessed without logging into the locked Electronic cabinet.<br><br>3. The record did not contain documentation that the follow up report was submitted to the State Agency within five days of the incident.<br><br>E. On 02/06/25 at 11:36 AM, during an interview with the DON, she confirmed the following:<br><br>1. The facility did not have any documentation that the follow-up report for R #200 was submitted to the State Agency.<br><br>2. The facility did not have any documentation that the follow-up report regarding the alleged diversion of medications from the Emergency Kit was submitted to the State Agency. |

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| F 0623<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights.<br><br>41755<br><br>Based on record review and interview, the facility failed to notify the resident and the resident's representative(s) of the transfer in writing for 5 (R #184, R #185, R #186, R #187 and R #188) of 6 (R #32, R #184, R #185, R #186, R #187, and R #188) residents sampled for hospitalization s or discharge when staff failed to:<br><br>1. Notify the resident and resident's representative(s) of the plan to discharge the resident from the facility in writing and in a language and manner they understand for R #184.<br><br>2. Notify the resident and resident's representative(s) of the resident's transfer to the hospital in writing and in a language and manner they understand for R #185, R #186, R #187, and R #188.<br><br>3. Include in the discharge or transfer notices a statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request.<br><br>4. Include in the transfer or discharge notices the name, phone number, and address (mailing and email) of the Office of the State Long-Term Care Ombudsman.<br><br>5. Send a written copy of the Discharge or Transfer Notices for R #184, R #185, R #186, R #187, and R #188 to the Ombudsman.<br><br>These deficient practices could likely result in the resident and/or their representative not knowing the reason for a transfer or discharge, the location of the transfer or discharge, and their rights to advocate and make informed decisions regarding the resident's healthcare. The findings are:<br><br>Discharge Notices<br><br>R #184<br><br>A. Record review of R #184's medical record revealed R #184 was discharged from the facility on 10/15/24.<br><br>B. On 01/30/25 at 11:20 AM, during an interview with R #184's Power of Attorney (POA, the authority to act for another person in specified or all legal or financial matters), the following was revealed:<br><br>1. She only received a one or two-day verbal notice from the Social Worker that the facility planned to discharge the resident.<br><br>2. She did not receive a written notice that the facility planned to discharge the resident.<br><br>(continued on next page) |

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| F 0623<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | 3. She was not notified about who to contact to appeal (apply for a decision to be reversed) R #184's discharge.<br><br>4. She was not notified of how to contact the Ombudsman.<br><br>5. She appealed R #184's discharge through the insurance three times.<br><br>6. She had to investigate the information for how to appeal the discharge on her own because the facility did not provide her with the information.<br><br>C. Record review of R #184's Notice of Medicare Non-Coverage, dated 10/07/24 revealed the following:<br><br>1. The form indicated R #184's skilled nursing services were going to end on 10/09/24.<br><br>2. The form indicated that the notice was provided telephonically or in person (does not specify if it was via phone or in person) to R #184's POA on 10/07/24 at 11:02 AM.<br><br>3. The form did not have a signature confirming that R #184's POA received the form.<br><br>D. Record review of R #184's Notice of Medicare Non-Coverage, dated 10/11/24 revealed the following:<br><br>1. R #184's skilled nursing services were going to end on 10/13/24.<br><br>2. The notice was provided telephonically or in person (does not specify if it was via phone or in person) to R #184's POA on 10/11/24 at 12:05 PM.<br><br>3. It did not have a signature confirming that R #184's POA received the form.<br><br>E. On 01/30/25 at 8:36 AM, during an interview with social services (SS), the following was confirmed:<br><br>1. R #184 was discharged home with family and caregivers on 10/15/24.<br><br>2. The family was provided with the Notice of Medicare Non-Coverage form each time the insurance determined they would not cover R #184's stay at the facility.<br><br>3. She did not provide R #184's POA with a written discharge notice that included how to appeal a discharge and how to contact the Ombudsman.<br><br>4. She did not provide a written notice of discharge to the Ombudsman after R #184's discharge.<br><br>hospitalization<br><br>R #185<br><br>F. Record review of R #185's medical record revealed the following:<br><br>(continued on next page) |

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| F 0623<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | 1. On 12/27/24, R #185 was sent to the hospital for altered mental status (change in mental function that stems from illnesses, disorders and injuries affecting your brain which can lead to changes in awareness, movement and behaviors).<br><br>2. The record did not contain any documentation of a written transfer notice.<br><br>R #186<br><br>G. Record review of R #186's medical record revealed the following:<br><br>1. On 09/06/24, R #186 was sent to the hospital for gastrointestinal bleeding (bleeding that occurs in the digestive tract).<br><br>2. On 09/23/24, R #186 was sent to the hospital for abdominal pain and distention (abnormal swelling or enlargement of the abdomen).<br><br>3. The record did not contain any documentation of a written transfer notice for 09/06/24 and 09/23/24.<br><br>R #187<br><br>H. Record review of R #187's medical record revealed the following:<br><br>1. On 12/21/24, R #187 was sent to the hospital due to low blood pressure.<br><br>2. The record did not contain any documentation of a written transfer notice.<br><br>R #188<br><br>I. Record review of R #188's medical record revealed the following:<br><br>1. On 12/18/24, R #188 was sent to the hospital due to elevated white blood cell count and uncontrolled pain.<br><br>2. The record did not contain any documentation of a written transfer notice.<br><br>J. On 01/21/25 at 3:35 PM, during an interview, RN #16 stated the following:<br><br>1. When a resident is transferred to the hospital the nurse does not complete a transfer notice.<br><br>2. The nurse contacts the family to notify them over the phone that the resident was sent to the hospital.<br><br>3. She confirmed she does not provide any transfer notice to the resident or resident representatives when a resident is transferred to the hospital.<br><br>K. On 01/21/25 at 3:40 PM, during an interview with the DON, she confirmed the following:<br><br>(continued on next page) |

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| F 0623<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | 1. The facility does not provide the residents with a written transfer notice at the time of transfer.<br><br>2. The SS provides discharge documents when residents discharge from the facility.<br><br>L. On 01/30/25 at 8:36 AM, during an interview with SS, she confirmed that she does not notify the Ombudsman about resident discharges or transfers to the hospital.<br><br>49313 |

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| F 0625<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave.<br><br>41755<br><br>Based on record review and interview, the facility failed to ensure residents, or their representatives received a written notice of the bed hold policy which indicated the duration the bed would be held for 4 (R #185, R #186, R #187, and R #188) of 4 (R #185, R #186, R #187, and R #188) residents reviewed for hospitalization . This deficient practice could likely result in the resident and/or their representative being unaware of the bed hold policy upon return from the hospital. The findings are:<br><br>R #185<br><br>A. Record review of R #185's medical record revealed the following:<br><br>1. On 12/27/24, R #185 was sent to the hospital for altered mental status (a change in a person's level of consciousness, awareness, and cognitive function).<br><br>2. The record did not contain any documentation of a written bed hold notice.<br><br>R #186<br><br>B. Record review of R #186's medical record revealed the following:<br><br>1. On 09/06/24, R #186 was sent to the hospital for gastrointestinal bleeding (bleeding that occurs in the digestive tract).<br><br>2. On 09/23/24, R #186 was sent to the hospital for abdominal pain and distention (abnormal swelling or enlargement of the abdomen).<br><br>3. The record did not contain any documentation of a written bed hold notice for 09/06/24 and 09/23/24.<br><br>R #187<br><br>C. Record review of R #187's medical record revealed the following:<br><br>1. On 12/21/24, R #187 was sent to the hospital due to low blood pressure.<br><br>2. The record did not contain any documentation of a written bed hold notice.<br><br>R #188<br><br>D. Record review of R #188's medical record revealed the following:<br><br>1. On 12/18/24, R #188 was sent to the hospital due to elevated white blood cell count and uncontrolled pain.<br><br>(continued on next page) |

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| F 0625<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | 2. The record did not contain any documentation of a written bed hold notice.<br><br>E. On 01/30/25 at 8:23 AM, during an interview with the DON, she confirmed the following:<br><br>1. R 185, R #186, R #187, and R #188 did not have a written bed hold notice.<br><br>2. Staff were expected to complete bed hold notices prior to sending residents to the hospital.<br><br>49313 |

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| F 0641<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Ensure each resident receives an accurate assessment.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41755<br><br>Based on interview and record review, the facility failed to ensure the Minimum Data Set Assessment (MDS; a standardized, comprehensive assessment of an adult's functional, medical, psychosocial, and cognitive status) was accurate for 4 (R #4, R #7, R #11, and R #184) of 5 (R #4, R #7, R #8, R #11, and R #184) residents reviewed for accurate MDS assessments. This deficient practice could likely result in the facility not having an accurate assessment of the resident's needs. The findings are:<br><br>R#4<br><br>A. Record review of R #4's admission record revealed R #4 was admitted on [DATE].<br><br>B. Record review of R #4's wound care consultation dated 12/25/24 revealed the following:<br><br>1. Stage II (shallow, open ulcer with a red-pink wound bed, without slough [non-viable tissue composed of dead cells accumulating on the wound surface. Can appear as a moist, yellow, tan, or white layer and is often fibrous or stringy in texture]) coccyx (tailbone, is a small triangle-shaped bone at the end of the spinal column) pressure ulcer<br><br>a. Coccyx (tailbone, is a small triangle-shaped bone at the end of the spinal column) wound present on arrival: Continue wound care. Turn every two hours to offload pressure points.<br><br>C. Record review of R #4's facility's provider progress notes revealed the following:<br><br>1. History and Physical dated 12/31/24<br><br>2. Coccyx wound present on arrival: Continue wound care. Turn every two hours to offload pressure points.<br><br>D. Record review of R #4's Admission MDS dated [DATE] revealed:<br><br>1. Section M0210, does this resident have one or more unhealed pressure ulcers/injuries?<br><br>a. Staff documented no.<br><br>E. On 01/30/25 at 4:12 PM, during an interview the DON confirmed R #4 did have pressure ulcer upon admission to the facility.<br><br>R #7<br><br>F. Record review of R #7's admission record revealed R #7 was admitted on [DATE].<br><br>G. Record review of R #7's nursing progress notes revealed on 12/06/24, R #7 fell in her room.<br><br>H. Record review of R #7's Admission MDS, dated [DATE], revealed the following:<br><br>(continued on next page) |

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| F 0641<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | 1. Section J1800 Has the resident had any falls since admission/entry?<br><br>a. Staff documented no falls since admission/entry.<br><br>I. On 01/30/25 at 3:42 PM, during an interview, the MDS coordinator confirmed R #7 did have a fall after admission and the MDS was not answered correctly.<br><br>R#11<br><br>J. Record review of R #11's admission record revealed the following:<br><br>1. admitted [DATE].<br><br>2. Diagnoses included the following:<br><br>a. Cellulitis (a common bacterial infection of the skin and underlying tissues) of Left Lower Limb<br><br>b. Cellulitis of Right Lower Limb<br><br>c. Sepsis (a life-threatening condition that occurs when the body's immune system overreacts to an infection), unspecified organism.<br><br>d. Methicillin Resistant Staphylococcus Aureus Infection (MRSA, infection is caused by a type of staph bacteria that's become resistant to many of the antibiotics used to treat ordinary staph infections) as the cause of Diseases Classified Elsewhere<br><br>e. Ileostomy (a surgical procedure that creates an opening (stoma) in the abdominal wall through which the ileum, the last part of the small intestine, is brought out onto the skin) Status<br><br>K. Record review of R #11's convalescent care orders (physician's orders at the time resident is admitted to a nursing facility after a hospital stay), dated 12/27/24, revealed the following:<br><br>1. R #11 had the following wounds:<br><br>a. Wound #1- Ulceration (an open sore or break in the skin that exposes underlying tissues) on the left upper arm.<br><br>b. Wound #2- Ulceration on left leg.<br><br>c. Wound #3- Ulceration on left foot.<br><br>d. Wound #4- Pressure wound (a localized area of skin damage that develops when prolonged pressure is applied to a specific area of the body) on the left heel.<br><br>e. Wound #5- Ulceration on right leg.<br><br>f. Wound #6- Surgical wound (an incision or cut made in the skin or underlying tissues during a surgical procedure) on midline (center) abdomen.<br><br>(continued on next page) |

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| F 0641<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | g. Wound #7- Stoma (a surgically created opening in the abdomen that allows waste to exit the body) to right lower abdomen.<br><br>L. Record review of R #11's Admission MDS, dated [DATE], revealed the following:<br><br>1. Staff documented the following:<br><br>a. R #11 had no pressure ulcers [R #11 had a pressure wound to his left heel].<br><br>b. R #11 had no other wounds present [R #11 had wounds to both lower legs, a surgical incision on the center of his abdomen and a recent colostomy (a surgical procedure that creates an opening (stoma) in the abdomen through which waste from the large intestine (colon) can be discharged into a bag)].<br><br>M. On 01/30/25 at 10:33 AM, during an interview with the MDS Coordinator, she confirmed the following:<br><br>1. R #11 was admitted to the facility on [DATE] with seven (7) wounds.<br><br>2. R #11's admission MDS, dated [DATE], did not include R #11's wounds.<br><br>3. R #11's wounds should have been included in the Admission MDS assessment dated [DATE].<br><br>R #184<br><br>N. Record review of R #184's admission record revealed R #184's admitted [DATE].<br><br>O. Record review of R #184's progress note, dated 09/25/24, revealed R #184 had Moisture Associated Skin Damage (MASD, a condition where prolonged exposure to moisture, such as urine, sweat, wound exudate, or saliva, leads to skin damage) due to incontinence (involuntary loss of urine or stool), to his buttocks.<br><br>P. Record review of R #184's Medicare 5-Day MDS Assessment, dated 09/27/25, revealed staff did not document that R #184 had MASD.<br><br>Q. On 01/30/25 at 10:09 AM, during an interview with the MDS Coordinator, she confirmed the following:<br><br>1. R #184's progress note dated 01/25/25 stated R #184 had MASD.<br><br>2. R #184's Medicare 5-Day MDS Assessment, did not include that R #184 had MASD.<br><br>3. Staff should have documented that R #184's had MASD on the Medicare 5-Day MDS Assessment.<br><br>49313 |

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| F 0655<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49313<br><br>Based on record review and interview, the facility failed to create an accurate baseline care plan (minimum healthcare information necessary to properly care for a resident immediately upon their admission to the facility) within 48 hours of admission for 3 (R #11, R #184, and #R #185) of 3 (R #11, R #184, and #R #185) residents reviewed for baseline care plans. This deficient practice could likely result in residents not receiving the appropriate care and may place residents at risk of an adverse event (undesirable experience, preventable or non-preventable, that caused harm to a resident because of medical care or lack of medical care) or worsening of current condition after admission. The findings are:<br><br>R #11<br><br>A. Record review of R #11's admission record revealed the following:<br><br>1. admitted [DATE].<br><br>2. Diagnoses included the following:<br><br>a. Cellulitis (a common bacterial infection of the skin and underlying tissues) of Left Lower Limb (left leg).<br><br>b. Cellulitis of Right Lower Limb<br><br>c. Sepsis (a life-threatening condition that occurs when the body's immune system overreacts to an infection), unspecified organism.<br><br>d. Methicillin Resistant Staphylococcus Aureus Infection (MRSA, infection is caused by a type of staph bacteria that's become resistant to many of the antibiotics used to treat ordinary staph infections) as the cause of Diseases Classified Elsewhere<br><br>e. Ileostomy (a surgical procedure that creates an opening (stoma) in the abdominal wall through which the ileum, the last part of the small intestine, is brought out onto the skin) Status<br><br>B. Record review of R #11's convalescent care orders (physician's orders that admit a patient to a nursing facility after a hospital stay), dated 12/27/24, revealed the following:<br><br>1. R #11 had the following wounds:<br><br>a. Wound #1- Ulceration (an open sore or break in the skin that exposes underlying tissues) on left upper arm.<br><br>b. Wound #2- Ulceration on left leg.<br><br>c. Wound #3- Ulceration on left foot.<br><br>(continued on next page) |

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| F 0655<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | d. Wound #4- Pressure wound (a localized area of skin damage that develops when prolonged pressure is applied to a specific area of the body) on left heel.<br><br>e. Wound #5- Ulceration on right leg.<br><br>f. Wound #6- Surgical wound (an incision or cut made in the skin or underlying tissues during a surgical procedure) on midline (center) abdomen.<br><br>g. Wound #7- Stoma (a surgically created opening in the abdomen that allows waste to exit the body) to right lower abdomen.<br><br>C. Record review of R #11's baseline care plan, dated 12/30/24, revealed R #12's baseline care plan did not include R #11 had wounds and any interventions that were in place to treat R #11's wounds.<br><br>D. On 01/30/25 at 10:33 AM, during an interview with the MDS Coordinator, she confirmed the following:<br><br>1. R #11 was admitted to the facility on [DATE] with seven (7) wounds.<br><br>2. R #11's baseline care plan did not include R #11 had wounds and any interventions to treat his wounds.<br><br>3. R #11's wounds should have been included in baseline care plan.<br><br>R #184<br><br>E. Record review of R #184's admission record revealed an admitted [DATE].<br><br>F. Record review of R #184's progress note, dated 09/25/24 at 1:36 AM, revealed R #184 had Moisture Associated Skin Damage (MASD, a condition where prolonged exposure to moisture, such as urine, sweat, wound exudate, or saliva, leads to skin damage) due to incontinence (involuntary loss of urine or stool), to his buttocks.<br><br>G. Record review of R #184's baseline care plan, dated 09/25/24, revealed the following:<br><br>1. R #184's baseline care plan was initiated on 09/25/24.<br><br>2. R #184's baseline care plan did not include R #184 MASD diagnosis and any interventions in place to treat it.<br><br>H. On 01/30/25 at 10:09 AM, during an interview with the MDS Coordinator, she confirmed the following:<br><br>1. Baseline care plans are expected to be completed within 48 hours of the resident's admission.<br><br>2. R #184's base line care plan was completed on 09/25/24, which was not within 48 hours of his admission.<br><br>(continued on next page) |

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| F 0655<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | 3. R #184's progress note on 09/25/24 at 1:36 AM, stated R #184 had MASD.<br><br>4. Staff did not document on R #184's baseline care plan that he had MASD.<br><br>5. Staff should have documented on R #184's baseline care plan that he had MASD.<br><br>R #185<br><br>I. Record review of R #185's admission record revealed the following:<br><br>1. admitted [DATE].<br><br>2. Diagnoses included the following:<br><br>a. Unspecified Severe Protein-Calorie Malnutrition (a condition where a person is experiencing significant deficiency in both protein and calories, leading to severe malnutrition, but the exact cause or specific presentation of this deficiency cannot be clearly identified or categorized medically).<br><br>b. Adult Failure to Thrive (a syndrome in older adults characterized by unexplained weight loss, decreased appetite, poor nutrition, inactivity, and a decline in overall physical and mental functioning)<br><br>c. Dysphagia (swallowing difficulties)<br><br>d. Gastrostomy status (presence of a gastrostomy, a surgical procedure that creates an opening in the stomach through the abdominal wall)<br><br>e. Unspecified B-Cell Lymphoma (type of cancer that develops in B cells, a type of white blood cell that plays a crucial role in the immune system), Lymph nodes (small, bean-shaped structures that play a crucial role in the body's immune system) of head, face, and neck<br><br>J. Record review of R #185's hospital records, dated 12/14/25, revealed R #185 had a percutaneous endoscopic gastrostomy (PEG tube, a thin, flexible tube inserted through the skin of the abdomen and into the stomach) placed on 12/13/25.<br><br>K. Record review of R #185's physician's orders, dated 12/18/25, revealed the following:<br><br>1. An order for enteral feed (a method of providing nutrition directly into the gastrointestinal (GI) tract through a tube) to be administered continuously through a pump at 65 mL per hour for 23 hours per day.<br><br>2. A diet order for a dysphagia diet (a modified diet designed for individuals with difficulty swallowing) with a puree texture (smooth, uniform texture, similar to pudding, with no lumps or stringy bits) and thick liquids of a nectar consistency (comparable to heavy syrup found in canned fruit).<br><br>L. Record review of R #185's base line care plan, dated 12/19/24, revealed the following:<br><br>(continued on next page) |

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| F 0655<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | 1. Staff did not document R #185's diagnosis of dysphagia.<br><br>2. Staff did not document on R #185's had a PEG tube.<br><br>3. Staff did not document R #185's order for enteral feedings.<br><br>4. Staff did not document R #185's diet order.<br><br>M. On 01/30/25 at 10:31 AM, during an interview with the MDS Coordinator, the following was confirmed:<br><br>1. Staff did not document the following on R #185's baseline care plan:<br><br>a. R #185 had a diagnosis of dysphagia.<br><br>b. R #185 had a PEG tube.<br><br>c. R #185 had diet orders for a dysphagia diet and thickened liquids.<br><br>d. R #185 had an order for enteral feedings.<br><br>2. Staff should have documented R #185's diagnosis of dysphagia, PEG tube, an order for enteral feedings, and his diet order. |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41755<br><br>Based on record review and interview, the facility failed to develop an accurate, person-centered comprehensive care plan for 3 (R #7, R #8, and R #184) of 5 (R #4, R #7, R #8, R #184, and R #191) residents reviewed for care plans. This deficient practice could likely result in staff being unaware of the current and actual needs of the residents. The findings are:<br><br>R #7<br><br>A. Record review of R #7's admission record (no date) revealed the following:<br><br>1. R #7 was admitted to the facility on [DATE].<br><br>2. Diagnosis: unspecified retinal detachment (serious eye condition where the retina [a light sensitive layer of tissue in the back of the eye] is pulled away from its normal position) with retinal break (when vitreous [clear jelly-like substance that fills the middle of the eye] pulls on the retina and causes a split) of the left eye.<br><br>B. Record review of R #7's Admission Minimum Data Set (MDS, federally mandated process for clinical assessment of all residents in Medicare or Medicaid-certified nursing homes) Assessment, dated 12/08/24, revealed the following:<br><br>1. Question B1000 Vision; Ability to see in adequate light.<br><br>a. Staff answered, severely impaired - no vision or sees only light, colors or shapes; eyes do not appear to follow objects.<br><br>C. Record review of R #7's care plan dated 12/04/24 revealed staff did not document R #7's severe vision impairment and how staff would assist the resident.<br><br>R #8<br><br>D. Record review of R #8's admission record (no date) revealed R #8 was admitted to the facility on [DATE]<br><br>E. Record review of R #8"s Admission Minimum Data Set Assessment, dated 12/29/24, revealed the following:<br><br>1. F0500 interview for activity preferences:<br><br>a. How important is it to listen to music you like? Resident response: Very important.<br><br>b. How important is it to you to keep up with the news? Resident response: Very important.<br><br>(continued on next page) |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | c. How important is it to you to go outside to get fresh air when the weather is good? Resident response: Very important.<br><br>d. How important is it to you to participate in religious services or practices? Resident response: Very important.<br><br>F. Record review of R #8's care plan dated 12/26/24 revealed staff did not document any of the activity preferences that were important to R #8.<br><br>R #184<br><br>G. Record review of R #184's admission record, no date, revealed the following:<br><br>1. R #184 was admitted to the facility on [DATE].<br><br>2. R #184 had the following diagnoses:<br><br>a. Unspecified lack of coordination (a condition that affects the body's ability to control and execute smooth, precise movements).<br><br>b. History of Falling<br><br>H. Record review of R #184's Admission Minimum Data Set Assessment, dated 08/19/24, revealed R #184 had the following functional abilities for Activity of Daily Living (ADL, fundamental skills needed to take care of oneself):<br><br>1. Eating: Supervision or touching assistance (Helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity. Assistance may be provided throughout the activity or intermittently).<br><br>2. Oral hygiene: Substantial/maximal assistance (Helper does more than half the effort. Helper lifts or holds trunk or limbs and provides more than half the effort).<br><br>3. Toileting hygiene: Substantial/maximal assistance<br><br>4. Shower/bathe self: Partial/moderate assistance (Helper does less than half the effort. Helper lifts, holds, or supports trunk or limbs, but provides less than half the effort).<br><br>5. Upper body dressing: Substantial/maximal assistance<br><br>6. Lower body dressing: Substantial/maximal assistance<br><br>7. Putting on/taking off footwear: Substantial/maximal assistance<br><br>8. Personal hygiene: Substantial/maximal assistance<br><br>9. Roll left and right: Substantial/maximal assistance<br><br>(continued on next page) |

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|---|---|
| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | 10. Sit to lying: Substantial/maximal assistance<br><br>11. Lying to sitting on side of bed: Substantial/maximal assistance<br><br>12. Sit to stand: Substantial/maximal assistance<br><br>13. Chair/bed-to-chair transfer: Substantial/maximal assistance<br><br>14. Toilet transfer: Substantial/maximal assistance<br><br>15. Tub/shower transfer: Substantial/maximal assistance<br><br>I. Record review of R #184's care plan, dated 09/25/24, revealed staff did not document R #184's functional level and the assistance needed to complete ADL's.<br><br>J. On 01/30/25 at 10:09 AM, during an interview with the MDS Coordinator, she confirmed R #184's care plan did not include his functional abilities. She confirmed that staff should have documented R #184's functional abilities in R #184's care plan.<br><br>49313 |

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| F 0657<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41755<br><br>Based on record review and interview, the facility failed to ensure care plan requirements were met for 4 (R #4, R #7, R #8, and R #19) of 6 (R #2, R #4, R #7, R #8, R #18, and R #19) residents reviewed for care plans when staff failed to:<br><br>1. Have the required Interdisciplinary Team (IDT, team members from different disciplines working collaboratively, with a common purpose, to set goals, make decisions and share resources and responsibilities) members participate in the care plan meeting for R #7, R #8, and R #19.<br><br>2. Revise the care plan with the most current resident information for R #4.<br><br>These deficient practices could likely result in the care plan not being updated with the most current resident conditions and appropriate interventions due to lack of participation of the entire IDT, staff being unaware of changes in care provided, and residents not receiving the care related to changes in their health status or healthcare decisions. The findings are:<br><br>IDT Team<br><br>R #7<br><br>A. Record review of the Post Admission Patient-Family Conference form dated 12/09/24, revealed R #7, nurse navigator, social services staff, rehabilitation (therapy services) staff and recreation staff, were present for the meeting.<br><br>B. Record review of R #7's care plan meeting note, dated 12/17/24, revealed R #7 and the social services worker were present for the meeting.<br><br>R #8<br><br>C. Record review of the Post Admission Patient-Family Conference form, dated 12/30/24, revealed R #8, dietary manager, R #8's family member (FM), nurse navigator, social services staff, rehabilitation staff and recreation staff were present for the meeting (no other care plan meetings were held for R #8).<br><br>R #19<br><br>D. Record review of R #19's care plan meeting note, dated 10/14/24, revealed R #19 and the social services worker were present for the meeting.<br><br>E. Record review of the Post Admission Patient-Family Conference form, dated 11/12/24, revealed the following:<br><br>1. The Patient/Family conference serves as the baseline care plan review and care plan meeting note.<br><br>(continued on next page) |

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| F 0657<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | 2. R #19, social services worker, and recreation worker were present for the meeting.<br><br>F. Record review of R #19's Post Admission Patient-Family Conference Form, dated 12/19/24, revealed R #19, family, nurse navigator, rehabilitation staff, and recreation worker were all present for the meeting.<br><br>G. On 01/30/25 at 3:04 PM, the social services worker revealed the following:<br><br>1. She is responsible for inviting people to the care plan meetings.<br><br>2. She invites the resident, their family, therapy director, the ADON (for nursing), activities, and dietary to the meetings.<br><br>3. She does not invite the CNA's and the providers to the meetings.<br><br>Care Plan Revision<br><br>R #4<br><br>H. Record review of R #4's admission record (no date) revealed R #4 was admitted to the facility on [DATE].<br><br>I. Record review of R #4's nursing progress notes, revealed the following:<br><br>1. Skilled evaluation note dated 01/10/25 staff documented:<br><br>a. New skin issue, right heel stage I (intact skin with non-blanchable [skin does not turn white when pressed] redness of a localized area usually over a bony prominence) pressure ulcer injury.<br><br>b. Wound acquired in house.<br><br>J. Record review of R #4's care plan initiated 12/30/24 revealed staff did not update R #4's care plan to document R #4's new pressure ulcer.<br><br>49313 |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate treatment and care according to orders, resident’s preferences and goals.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49313<br><br>Based on record review and interview, the facility failed to ensure residents received treatment and care in accordance with professional standards of practice for 2 (R #11 and R #184) of 2 (R #11 and R #184) residents when staff failed to:<br><br>1. Implement convalescent care orders (physician's orders that admit a patient to a nursing facility after a hospital stay) for R #11 wounds.<br><br>2. Assess R #11's wounds upon admission.<br><br>3. Notify the provider when R #184 developed Moisture Associated Skin Damage (MASD, a condition where prolonged exposure to moisture, such as urine, sweat, wound exudate, or saliva, leads to skin damage).<br><br>Failure to implement convalescent care orders and notify the provider about changes in resident conditions could likely lead to facility staff and the physician being unaware of changes in resident condition and could likely lead to worsening of resident's condition. The findings are:<br><br>R #11<br><br>A. Record review of R #11's admission record revealed the following:<br><br>1. admitted [DATE].<br><br>2. Diagnoses included the following:<br><br>a. Cellulitis (a common bacterial infection of the skin and underlying tissues) of Left Lower Limb<br><br>b. Cellulitis of Right Lower Limb<br><br>c. Sepsis (a life-threatening condition that occurs when the body's immune system overreacts to an infection), unspecified organism.<br><br>d. Methicillin Resistant Staphylococcus Aureus Infection (MRSA, infection is caused by a type of staph bacteria that's become resistant to many of the antibiotics used to treat ordinary staph infections) as the cause of Diseases Classified Elsewhere<br><br>e. Ileostomy (a surgical procedure that creates an opening (stoma) in the abdominal wall through which the ileum, the last part of the small intestine, is brought out onto the skin) Status<br><br>B. Record review of R #11's convalescent care orders, dated 12/27/24, revealed the following:<br><br>1. Continue with wound treatment orders.<br><br>2. R #11 had the following wounds and wound treatment orders:<br><br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | a. Wound #1- Ulceration (an open sore or break in the skin that exposes underlying tissues) on left upper arm.<br><br>- Wound Care Orders- Apply Xeroform (non-adherent gauze dressing used to treat wounds, burns, and skin abrasions) and mepilex (a soft, absorbent foam dressing used to treat wounds) border.<br><br>b. Wound #2- Multiple scattered ulcerations on left leg.<br><br>-Wound Care Orders- Apply xeroform with medihoney (a topical wound dressing made from medical-grade active Leptospermum honey). Apply kerlix (a brand of gauze bandage rolls that are used to cover wounds and absorb drainage) and ace wrap (a self-adhering medical device used to provide compression and support to injured or swollen areas).<br><br>c. Wound #3- Ulceration on left foot.<br><br>-Wound Care Orders- Apply xeroform with medihoney. Apply kerlix and acewrap.<br><br>d. Wound #4- Pressure wound (a localized area of skin damage that develops when prolonged pressure is applied to a specific area of the body) on left heel.<br><br>- Wound Care Orders- Apply mepilex foam and offload (a treatment for pressure ulcers that involves reducing pressure on the affected area).<br><br>e. Wound #5- Ulceration on right leg.<br><br>- Wound Care Orders- Apply xeroform with medihoney. Apply kerlix and acewrap.<br><br>f. Wound #6- Surgical wound (an incision or cut made in the skin or underlying tissues during a surgical procedure) on midline (center) abdomen with staples present.<br><br>- Wound Care Orders- Clean with normal saline and cover with mepilex.<br><br>g. Wound #7- Stoma (a surgically created opening in the abdomen that allows waste to exit the body) to right lower abdomen.<br><br>- Wound Care Orders- Ostomy Care (cleaning the skin around the stoma and changing the ostomy pouch).<br><br>C. Record review of R #11's admission assessment, dated 12/27/24, revealed staff did not assess R #11's skin.<br><br>D. Record review of R #11's skin assessment, dated 12/28/24, revealed staff documented R #11 had a surgical incision to his midline abdomen with staples, a colostomy, and scattered scabbing to bilateral lower extremities.<br><br>E. Record review of R #11's physician's orders, dated 01/03/24, revealed the following:<br><br>1. Wound care for both lower legs every other day.<br><br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | 2. Wound care for both lower legs as needed.<br><br>3. Wound care and off load left heel every other day and as needed.<br><br>4. The medical record did not contain any wound care orders between R #11's admission on 12/27/24 and 01/02/25.<br><br>F. Record review of R #11's entire medical record, no date, revealed staff did not document that the provider was contacted for wound care orders regarding R #11's prior to 01/03/25.<br><br>G. Record review of R #11's entire medical record, no date, revealed staff did not document that wound care was completed for R #11 between 12/27/24 and 01/02/25.<br><br>H. On 01/17/25 at 11:23 AM, during an interview with the ADON, the following was confirmed:<br><br>1. R #11's convalescent care orders stated R #11 had seven (7) wounds.<br><br>2. Staff did not document any wound care orders for R #11 until 01/03/25.<br><br>3. Staff did not document that R #11 received any wound care prior to 01/03/25.<br><br>4. The admission nurse should have entered the convalescent care orders into R #11's medical record at the time of admission.<br><br>5. The admission nurse should have completed a skin assessment during admission.<br><br>6. He was unable to determine if R #11 received any wound care between 12/27/24 and 01/02/25.<br><br>R #184<br><br>I. Record review of R #184's admission record revealed an admitted [DATE].<br><br>J. Record review of R #184's progress notes, multiple dates, revealed the following:<br><br>1. On 09/25/24 staff documented R #184 had a 6 centimeter (cm) long and 6 cm wide MASD due to incontinence (involuntary loss of urine or stool), on his buttocks.<br><br>2. On 09/27/24, staff documented R #184 had a 6 centimeter (cm) long and 6 cm wide MASD on his buttocks due to incontinence.<br><br>3. On 09/28/24, staff documented R #184 had a 6 centimeter (cm) long and 6 cm wide MASD on his buttocks due to incontinence.<br><br>4. On 09/29/24, staff documented R #184 had a 6 centimeter (cm) long and 6 cm wide MASD on his buttocks due to incontinence.<br><br>5. On 10/01/24, staff documented R #184 had a 6 centimeter (cm) long and 6 cm wide MASD on his buttocks due to incontinence.<br><br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | 6. On 10/02/24, staff documented R #184 had a 6 centimeter (cm) long and 6 cm wide MASD on his buttocks due to incontinence.<br><br>7. On 10/03/24, staff documented R #184 had a 6 centimeter (cm) long and 6 cm wide MASD on his buttocks due to incontinence.<br><br>8. On 10/09/24, staff documented R #184 had a 6 centimeter (cm) long and 6 cm wide MASD on his buttocks due to incontinence.<br><br>9. On 10/10/24, staff documented R #184 had a 6 centimeter (cm) long and 6 cm wide MASD on his buttocks due to incontinence.<br><br>10. On 10/11/24, staff documented R #184 had a 6 centimeter (cm) long and 6 cm wide MASD on his buttocks due to incontinence.<br><br>11. On 10/12/24, staff documented R #184 had a 6 centimeter (cm) long and 6 cm wide MASD on his buttocks due to incontinence.<br><br>12. On 10/13/24, staff documented R #184 had a 6 centimeter (cm) long and 6 cm wide MASD on his buttocks due to incontinence.<br><br>13. Staff did not document that the provider was notified about R #184 having MASD.<br><br>14. Staff did not document that any treatment for R #184's MASD was provided.<br><br>K. Record review of R # 184's physician's orders, no date, revealed the medical record did not contain any orders to treat R #184's MASD.<br><br>L. On 01/29/25 at 3:16 PM, during an interview, CNA #16 stated if a resident develops redness to the skin or any changes to the skin, the CNA is expected to notify the nurse so the nurse can assess the resident and tell the CNA if they are supposed to apply barrier cream (to create a protective barrier on the skin's surface) to the area.<br><br>M. On 01/29/25 at 3:19 PM, during an interview with RN #16, the following was revealed:<br><br>1. If the nurse is notified by the CNA that a resident developed redness or skin changes, the nurse is expected to assess the resident's skin to determine what kind of skin issue the resident has.<br><br>2. The nurse is expected to contact the provider to get orders.<br><br>3. She confirmed that staff did not document in R #184's medical record that the provider was notified about his MASD.<br><br>4. She confirmed that R #184's medical record did not have any orders to treat his MASD.<br><br>N. 01/30/25 at 2:58 PM, during an interview with the DON, the following was confirmed:<br><br>1. R #184 had MASD.<br><br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | 2. R #184's medical record did not contain any documentation that the provider was notified about his MASD.<br><br>3. Staff should have notified the physician and the resident's family about his skin changes.<br><br>4. Staff should have documented any communication with the provider and family about his skin changes.<br><br>5. Any orders received from the provider should be documented and followed. |

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| F 0686<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate pressure ulcer care and prevent new ulcers from developing.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41755<br><br>Based on record review and interview, the facility failed to ensure wound care orders were obtained and implemented and wound care was completed for 1 (R #4) of 3 (R #4, R #11, and R #28) residents reviewed for pressure ulcers (damage to an area of the skin caused by constant pressure on the area for a long time). These deficient could likely result in the provider being unaware of the resident's current condition, leading to inconsistent interventions and worsening of pressure ulcers. The findings are:<br><br>A. Record review of R #4's admission record (no date) revealed R #4 was admitted to the facility on [DATE].<br><br>B. Record review of the wound care consultation (outside wound care provider) note dated 12/25/24 revealed the following:<br><br>1. Stage II (shallow, open ulcer with a red-pink wound bed, without slough [non-viable tissue composed of dead cells accumulating on the wound surface. Can appear as a moist, yellow, tan, or white layer and is often fibrous or stringy in texture]) coccyx (tailbone, is a small triangle-shaped bone at the end of the spinal column) pressure ulcer<br><br>a. Coccyx (tailbone, is a small triangle-shaped bone at the end of the spinal column) wound present on arrival: Continue wound care. Turn every two hours to offload pressure points.<br><br>C. Record review of R #4's facility's provider progress notes revealed the following:<br><br>1. History and Physical (H and P; most formal and complete assessment of the patient and the problem is a formal document that providers produce through the interview with the patient, the physical exam, and the summary of the testing either obtained or pending) dated 12/31/24<br><br>a. Coccyx wound present on arrival: Continue wound care.<br><br>D. Record review of R #4's Dietitian assessment note dated 01/06/25 revealed the following:<br><br>1. R #4 was admitted with a wound to coccyx.<br><br>2. R #4 is at nutritional risk due to skin breakdown.<br><br>E. Record review of R #4's physician's orders revealed an order date 01/11/25, Wound care - Sacrum (area of spinal column just above the coccyx) apply Allevyn sacrum dressing (name brand, highly absorbent adhesive sacral shaped foam dressing with waterproof and bacteria proof outer film layer) for pressure relief on bony prominence. Maintain dressing clean dry and intact. Change every other day and as needed one time a day every other day.<br><br>F. Record review of R #4's Treatment Administration Record (TAR, electronic document where facility staff document wound care was completed) for December 2024 revealed facility staff did not have orders in place for treatment of R #4's pressure ulcer for 12/30/24 and 12/31/24.<br><br>(continued on next page) |

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| F 0686<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | G. Record review of R #4's TAR for January 2025 revealed facility staff did not have orders in place for treatment of R #4's pressure ulcer until 01/11/25.<br><br>H. Record review of R #4's Nursing Progress Notes dated 12/30/24 through 01/11/24 revealed staff did not consult with the facility provider to obtain wound care orders.<br><br>I. On 01/30/25 at 4:12 PM, during an interview, the DON stated the following:<br><br>1. Nursing staff are not identifying wounds for residents upon admission.<br><br>2. Nursing staff did not obtain orders for R #4's pressure ulcer which was present on admission.<br><br>3. It is her expectation that orders be obtained on admission if residents are admitted with pressure ulcers. |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.<br><br>47510<br><br>Based on observation, and interview the facility failed to keep the residents free from accidents for all 14 residents on the East Unit (Residents were identified by the resident Census provided by the Administrator on 01/14/25), when they failed to keep treatment carts (a movable piece of equipment used in healthcare facilities to store, transport, and dispense treatment supplies and tools) locked when not supervised by staff. This deficient practice could likely result in injury to residents obtaining medical equipment which can cause injury/death:. The findings are:<br><br>A. On 01/15/25 at 9:12 AM, during an observation of the East Unit, the IV (intravenous, within vein) treatment cart was unlocked and opened, the cart had sterile needles, and intravenous catheters (a thin, flexible tube inserted into a vein to deliver fluids). Staff were not present.<br><br>B. On 01/15/25 at 9:14 AM, during an interview, RN #8 confirmed the IV treatment cart was unlocked and opened. She said the treatment cart should be locked when not in their sight or control.<br><br>C. On 01/15/25 at 9:16 AM, during an observation of the East Unit, the treatment cart was unlocked and opened, the cart had diclofenac (anti-inflammatory), bacitracin (antibiotic cream), nystati (antibiotic cream), mupirocin (antibiotic cream), silvasorb (antimicrobial wound dressing) lotions, and scissors. Staff were not present.<br><br>D. On 01/15/25 at 9:19 AM, during an interview, LPN #8 confirmed the treatment cart was unlocked and opened, even though the treatment cart is supposed to be locked. |

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| F 0690<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.<br><br>47510<br><br>Based on observation, record review and interview, the facility failed to ensure a resident with a condom catheter (an external urinary device that collects urine from men with urinary incontinence or difficulty urinating) had an order and clinical condition that demonstrated that a condom catheter was necessary for 1 (R #191) of 1 (R #191) residents reviewed for catheter use. This deficient practice could likely result in an increased and unnecessary risk of a urinary tract infection (bacteria in the urinary tract).<br><br>A. On 01/15/25 at 1:53 PM, during an interview, R #191 said he had a catheter to streamline the process of elimination. R #191 said that he is continent of bowel and bladder.<br><br>B. On 01/15/25 at 1:54 PM, during an observation of R #191, revealed R #191 had a catheter.<br><br>C. Record review of R #191's physicians orders revealed R #191 did not have an order for a condom catheter.<br><br>D. Record review of R #191's medical record revealed the record did not contain any documentation of a clinical condition for the need of a condom catheter.<br><br>E. On 01/17/25 at 2:30 PM, during an interview, the DON confirmed she did not see an order, or a clinical condition documented for R #191's catheter. The DON said that the expectation is that all residents have orders for catheters and that there should be a clinical reason for the resident to have a catheter. |

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| F 0695<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide safe and appropriate respiratory care for a resident when needed.<br><br>47510<br><br>Based on observation, interview, and record review, the facility failed to provide respiratory care (health care discipline specializing in the promotion of optimum cardiopulmonary function, health and wellness) that was consistent with professional standards of practice for 1 (R #2) of 1 (R #2) resident sampled for respiratory care when staff failed to change R #2's nasal cannula (medical device to provide supplemental oxygen therapy to through the nose) within 7 days of the previous change. This deficient practice could likely cause the nasal cannula to become obstructed, non-functional, and unsanitary and not provide the resident with the oxygen needed. The findings are:<br><br>A. On 01/15/25 at 11:03 AM, during an observation of R #2 revealed R #2 had a portable oxygen tank and nasal cannulas. The nasal cannulas were not dated with a date indicating the date they had been changed.<br><br>B. Record review of R #2's Physicians Orders dated 12/18/24 revealed Oxygen at 2 Liters to be administer via nasal cannula continuously.<br><br>C. On 01/16/25 at 1:51 PM, during an interview, the DON stated the oxygen cannula's are changed once a week, usually on Sundays. The DON said that there should be a piece of tape on the tubing with a date to document when the tubing was changed. The DON stated that the tape on the tubing is how they document when it was changed.<br><br>D. On 01/16/23 at 1:55 PM, during an interview CNA #8 confirmed R #2's cannula does not have a date indicating when the cannula was changed. CNA #8 said that the cannulas are usually changed on Sundays and she could not confirm if R #2's cannula had been changed. |

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| F 0732<br><br>Level of Harm - Potential for minimal harm<br><br>Residents Affected - Many | Post nurse staffing information every day.<br><br>41755<br><br>Based on observation and interview, the facility failed to post nurse staffing data on a daily basis that included the following:<br><br>1. The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift to include:<br><br>a. Registered nurses.<br><br>b. Licensed practical nurses.<br><br>c. Certified nurse aides.<br><br>This deficient practice could likely result in residents not knowing which staff is working. The findings are:<br><br>A. On 01/30/25 at 3:29 PM, during an observation of the facility, revealed the nurse staffing data posted at the front entrance of the facility did not include the total number of actual nursing staff scheduled and actual hours worked by nursing staff for the day.<br><br>B. On 01/30/25 at 4:15 PM, during an interview, the DON confirmed the night shift nurse is responsible for posting the nurse staffing data and it should include the total number of staff scheduled for each shift and the number of hours that each nursing staff is scheduled to work. |

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| F 0758<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49313<br><br>Based on record review and interview, the facility failed to ensure residents did not receive psychotropic medications (antidepressants, anti-anxiety medications, stimulants, antipsychotics, and mood stabilizers) unless the medication was medically necessary for 1 (R #198) of 5 (R #2, R #7, R #19, R #28, and R #198) residents reviewed for unnecessary medications. This deficient practice could likely result in residents receiving medications without a medical reason or when the medication is no longer necessary, placing these residents at a higher risk of adverse side effects (unwanted, harmful, or abnormal result). The findings are:<br><br>A. Record review of R #198's admission record, no date, revealed the following:<br><br>1. R #198 was admitted to the facility on [DATE].<br><br>2. R #198 had the following diagnoses:<br><br>a. Cognitive communication deficit (a difficulty with communication caused by an impairment in cognitive processes).<br><br>b. Other symbolic dysfunctions (language impairments caused by an underlying medical condition).<br><br>c. Dementia (a syndrome characterized by a progressive decline in cognitive functions, such as memory, thinking, reasoning, and problem-solving, that interferes with daily life and activities) in other diseases classified elsewhere, severe, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety (a diagnosis given to people with dementia who have no behavioral disturbances).<br><br>B. Record review of R #198's physician's order, dated 01/11/25, revealed an order for Remeron (antidepressant medication commonly used to treat depression) 15 mg at bedtime for muscle weakness.<br><br>C. Record review of R #198's Medication Administration Record, dated January 2025, revealed staff documented that R #198 was administered Remeron every evening beginning on 01/11/25.<br><br>D. On 01/30/25 at 3:18 PM, during an interview with the DON, the following was confirmed:<br><br>1. R #198 had an order for Remeron for muscle weakness.<br><br>2. R #198 did not have a medical diagnosis appropriate for the use of Remeron. |

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| F 0761<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.<br><br>49313<br><br>Based on observation and interview, the facility failed to properly store medications, when staff failed to ensure medications were not expired in medication cart for all 14 residents on the East Unit (Residents were identified by the resident matrix provided by the Administrator on 01/15/25).<br><br>This deficient practice could likely result in residents obtaining medications that are no longer effective, resulting in adverse side effects. The findings are:<br><br>A. On 01/21/25 at 3:25 PM, an observation of the medication cart on the East Unit revealed fish oil supplement (a supplement used to help reduce pain, improve morning stiffness and relieve joint tenderness in people with rheumatoid arthritis), 1000 mg, expired on 12/2024.<br><br>B. On 01/21/25 at 3:27 PM, during an interview with RN #16, she confirmed the bottle of Fish Oil 1000 mg was expired and should not have been in the medication cart.<br><br>C. On 01/21/25 at 3:35 PM, during an interview with the DON, she confirmed expired medications should not be in the medication carts. Nurses should check for expired medications in the medication carts each shift. |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 325111 | A. Building<br>B. Wing | 01/30/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| The Village at Northrise - Desert Willow I | 2884 North Road Runner Parkway<br>Las Cruces, NM 88011 |

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

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Provide and implement an infection prevention and control program.<br><br>49313<br><br>Based on record review and interview, the facility failed to maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment to help prevent the development and transmission of communicable diseases and infections when they failed to have a water management program to minimize the risk of Legionella [a bacteria that can grow in parts of building water systems that are continually wet (e.g., pipes, faucets, water storage tanks, decorative fountains) and cause a serious type of pneumonia], and other opportunistic pathogens (bacteria that do not usually cause diseases in healthy people but may become extremely injurious to unhealthy individuals) in the building's water system. This failure could potentially affect all (27) residents who live in the facility (residents were identified by the Resident Matrix provided by the Administrator on 01/15/25).<br><br>If the facility fails to maintain an effective infection control program, then infections could spread to residents throughout the facility, resulting in illness. The findings are:<br><br>A. Record review of the facility's Water Management Policy, revised 09/13/24, revealed the following:<br><br>1. The facility will develop a Water Management Plan that is overseen by the water management plan team.<br><br>2. Water management team consists of Center leadership, infection preventionist, maintenance employees, safety officers, risk and quality management staff, and the Director of Nursing.<br><br>3. To minimize exposure to Legionella and other water-borne pathogens to our patients, family members, staff, and visitors.<br><br>4. The Maintenance Director maintains documentation in the TELS (is a building management platform designed for Senior Living with integrated Asset Management, Life Safety, and Maintenance solutions) Water Management Plan that describes the Center's water system.<br><br>5. A risk assessment will be conducted by the water management team annually to identify where Legionella and other opportunistic waterborne pathogens could grown and spread in the facilities water systems.<br><br>6. Data to be used for completing the risk assessment may include, but are not limited to:<br><br>a. Water system schematic/description;<br><br>b. Legionella environment assessment;<br><br>c. Patient infection control surveillance data;<br><br>d. Environment culture results;<br><br>(continued on next page) |

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|---|---|---|---|
| | 325111 | A. Building<br>B. Wing | 01/30/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| The Village at Northrise - Desert Willow I | 2884 North Road Runner Parkway<br>Las Cruces, NM 88011 |

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|---|---|
| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | e. Rounding observation data;<br><br>f. Water temperature logs;<br><br>g. Water quality reports from drinking water provider;<br><br>h. Community infection surveillance data.<br><br>B. On 01/29/25 at 3:46 PM, during an interview with the Director of Maintenance, stated the following:<br><br>1. He has been the Director of Maintenance since 10/2023.<br><br>2. He was not aware of anything that was supposed to be done to prevent the growth of Legionella or other waterborne pathogen.<br><br>3. The previous administrator handled water management.<br><br>4. The previous administrator left in May or June 2024.<br><br>C. On 01/29/25 at 3:44 PM, during an interview with the DON, stated the following:<br><br>1. She has not been involved in any meetings regarding preventing the growth of Legionella or other waterborne pathogens.<br><br>2. She has not done anything for the management of Legionella or other waterborne pathogens.<br><br>D. On 01/30/25 at 8:26 AM, during an interview with the Administrator, the following was confirmed:<br><br>1. The Director of Maintenance should have a diagram of the water system and any areas where Legionella or other waterborne pathogens could grow.<br><br>2. He was not aware of who was on the Water Management Plan team.<br><br>3. He has not been involved in any meetings about water management. |

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|---|---|---|---|
| | 325111 | A. Building<br>B. Wing | 01/30/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| The Village at Northrise - Desert Willow I | 2884 North Road Runner Parkway<br>Las Cruces, NM 88011 |

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|---|---|
| F 0882<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Designate a qualified infection preventionist to be responsible for the infection prevent and control program in the nursing home.<br><br>49313<br><br>Based on interview and record review, the facility failed to designate a qualified, trained, or certified Infection Preventionist (IP) who was responsible for the facility's Infection Prevention and Control Program (IPCP.) This failure could affect all 27 residents in the facility (residents were identified by the resident matrix provided by the Administrator on 01/08/24). This deficient practice could likely result in residents being at greater risk of infectious disease. The findings are:<br><br>A. On 01/29/24 at 3:33 PM, during an interview, the DON stated the following:<br><br>1. The IP had some issues with her nursing license.<br><br>2. The IP has been on leave due to the issues with her nursing license since 01/10/25.<br><br>3. She is now performing IP duties.<br><br>4. She is working to obtain her IP certification.<br><br>B. Record review of the former IP's time sheet, no date, confirmed she last worked at the facility on 01/10/25. |

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| | 325111 | A. Building<br>B. Wing | 01/30/2025 |

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|---|---|
| F 0919<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Make sure that a working call system is available in each resident's bathroom and bathing area.<br><br>47510<br><br>Based on observation and interview, the facility failed to ensure the call light pull cords in resident's rooms were adequately equipped to allow residents to call for help using the call light system for 3 (R #4, R #8, and R #15) of 3 (R #4, R #8, and R #15) when the facility failed to have proper pull cords on the call light system in the resident's rooms when they could not be reached if the resident was not in bed. This deficient practice could likely result in residents being unable to call for assistance. The findings are:<br><br>R #4<br><br>A. 01/15/25 3:48 PM, during an interview, R #4's wife said that R #4 was not cognizant (not having knowledge or being aware of) enough to pull the cord on the call light. R #4 had no other option for the calling for help.<br><br>R #8<br><br>B. On 01/15/25 at 11:01 AM, during an interview and observation of R #8's room revealed a trash bag was tied to the end of the call light. R #8 said that the cord on his call light is too short and he can't reach the call light. R #8 said he didn't know why the trash bag was tied to the cord except to maybe make it longer.<br><br>R #15<br><br>C. On 01/30/25 at 11:43 AM during an observation of resident's rooms, revealed R #15 can not reach the call light from his bed. During an interview, the Maintenance Director (MD) #1 confirmed R #15 can't reach his call light while he is out of bed.<br><br>D. On 01/30/25 at 10:59 AM, during an interview, MD #1 confirmed the pull cords for the call lights for R #4 and R #8 can only be reached if the residents are laying in their beds. MD #1 confirmed that if R #4 and R #8 could not use their call lights to call for help while not in bed. MD #1 confirmed that none of the pull cords in the resident's rooms in the facility could be reached if residents were not in their beds. MD #1 said the cord used to be longer but would get tangled up so they made them shorter. MD #1 said that the cord attached to the call light on the wall was the only option for call lights. MD #1 said that they did not have any way to modify the pull cord for residents that were not cognizant enough to pull the cord. MD #1 said that some of the cords had bags tied to them because it made it easier for the resident's to grip. |