STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	325113	A. Building B. Wing	08/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cedar Ridge Inn	800 Saguaro Trail Farmington, NM 87401

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. (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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F 0686 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to prevent the worsening of a pressure ulcer (PU; an injury to skin and underlying tissue resulting from prolonged pressure on the skin) for 1 (R #10) of 3 (R #10, #12 and #13) residents when staff failed to notify the physician when the resident's right gluteal fold (buttocks) wound worsened. If the facility does not recognize and notify the physician when a wound deteriorates, then the wound may worsen, become infected, and result in hospitalization. The findings are: A. Record review of R #10's face sheet revealed an initial admission date of 12/02/21 with a diagnosis of multiple sclerosis (MS; a chronic progressive disease involving damage to the nerve cells in the brain and spinal cord, which may cause numbness, impairment of speech and muscular coordination, blurred vision and severe fatigue). B. Record review of R #10's care plan, dated 09/09/24, revealed R #10 was dependent on staff assistance for all activities of daily living (ADL; activities related to personal care such as bathing, showering, dressing, walking, toileting, and eating). C. Record review of R #10's wound assessment revealed the following: -On 07/17/25, an abrasion (partial thickness wound caused by damage to the skin) on R #10's right gluteal fold. Length (l) 0.82 centimeters (cm), width 0.6 cm. -On 07/31/25, an abrasion on R #10's right gluteal fold. Length 2.24 cm, width 1.19 cm, depth 1 cm. -On 08/06/25, an abrasion on R #10's right gluteal fold. Length 5.6 cm, width 3.12 cm. The wound was 70 percent (%) slough (yellow stringy tissue adhered to wound bed). - On 08/11/25, an abrasion on R #10's right gluteal fold. Length 3.7 cm, width 2.49 cm, depth 2. 5 cm. The wound had a suspected infection and was 70% slough with increased drainage. - On 08/19/25, a stage III pressure sore (full thickness skin loss that extends into deeper tissue and fat but not into muscle, tendon, or bone) on R #10's right gluteal fold. Length 3.9 cm, width 3.17 cm, depth was 3.5 cm. The wound was debrided (medical removal of dead, damaged, or infected tissue) at the hospital, and a negative pressure wound therapy (NPWT; a treatment that uses suction to help wounds heal) was put into place. - On 08/25/25, a stage III pressure sore on R #10's right gluteal fold. Length 4.59 cm, width 3.31 cm, depth was 3.5 cm. The wound was 30 percent slough (yellow stringy tissue adhered to wound bed). D. Record review of R #10's physician orders revealed the following: - Monitor open area to right buttock for signs and symptoms of infection. Notify medical doctor (MD) for any changes every shift. Start 07/17/25 and end on 08/05/25. -Right buttock open area: Cleanse site with wound cleanser and apply foam dressing, daily every day shift for wound. Start date 07/18/25 and end on 07/31/25. -Right buttock open area: Cleanse site wound cleanser and apply skin prep to periwound. Apply collagen to wound bed and cover with mepilex (foam dressing for acute and chronic wounds). Change dressing as needed. May discontinue when resolved. Complete every day shift for wound care. Start date 08/01/25 and end on 08/04/25. -Right buttock open area: Cleanse site wound cleanser, apply skin prep to peri wound, apply medihoney (wound and burn gel) to wound bed cover with mepilex. Start on 08/04/25 and end on 08/05/25. -Right gluteal (buttock) fold: Unstageable [a wound that has full thickness tissue loss but is covered with slough (dead tissue) or eschar (dark scab or falling away of dead skin) so that the true depth of the wound cannot be determined] pressure ulcer. Clean wound and dry with gauze. Apply a thin layer of Santyl (medication used to treat severe burn or skin ulcers by removing dead skin tissue and aid in wound healing) to wound bed. Cover with a foam bordered dressing. Start date 08/05/25 and end on 08/06/25. - Wound Care to right Gluteal fold unstageable PU: Clean wound and dry with gauze, apply skin prep to peri wound, apply a thin layer of Santyl to wound bed, cover with a foam bordered dressing. May change as needed if dressing is soiled. Every shift for wound care. Start date 08/08/25 0846 and end date 08/13/25. E. Record review of R #10's Medication Administration Record (MAR) dated 07/18/25 to 07/31/25, revealed the following: - Staff did not provide wound care to R #10 on 07/28/25. The record did not state why the wound care was not provided. - Staff did not provide wound care to R #10 on 07/29/25. The record did not state why the wound care was not provided. F. Record review of R #10's MAR, dated 08/01/25 to 08/06/25, revealed the following: - Staff did not provide wound care to R #10 on 08/01/25. The record did not state why the wound care was not provided. G. Record review of R #10's electronic health record revealed the following: -The record did not contain any progress notes indicating staff notified the physician of the resident's deteriorating wound from 07/17/25 to 08/05/25. -The record did not contain an order to send the resident out to the hospital. H. Record review of R #10's admission hospital record, dated 08/11/25, revealed R #10 had altered mental status (a change in mental function related to brain issues) at the facility and was picked up by an ambulance. The

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on observation, interview and record review the facility failed to secure an oxygen cylinder to prevent tipping and falling over for 1 (R #13) of 2 (R #13 and R #14) residents. If the oxygen container fell over, then the valve could break on the canister and cause the residual oxygen to leak or cause the oxygen cylinder to self-propel across the facility. The findings are: A. Record review of the facility's oxygen safety policy, last revised 2025, indicated oxygen cylinders will be properly chained or supported in racks or other fastenings (sturdy portable carts, approved stands) to secure all cylinders from falling, whether connected, unconnected, full or empty. B. On 08/26/25 at 10:35 am, an observation revealed R #13's oxygen tank sat unsecured next to her recliner. R #13 was not using the oxygen. C. On 08/26/25 at 10:35 am, during an interview, the Director of Nursing (DON) stated the portable oxygen container should not be in R #13's room. She stated oxygen cylinders should not be stored unsecured, because it could cause an accident.