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	04/28/2026

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. Based on record review and interviews, the facility failed to provide quality care that meets professional standards for 1 (R #2) of 3 (R #2, #3, and #7) residents reviewed, when staff: Discontinued an eye drop medication without a physician's order and authorization. This deficient practice is likely to result in residents not maintaining their optimal health as planned by their medical provider, and potential complications. The findings are: A. Record review of R #2's face sheet revealed an admission date of 07/01/23 with the following diagnoses:Cerebral infarction (the death of brain tissue due to lack of blood flow),Dementia (symptoms affecting memory, thinking and social abilities severely enough to interfere with your daily life),Glaucoma (a group of eye conditions that can cause blindness). B. Record review of R #2's physician orders revealed the following: Start date of 02/23/26, Dorzolamide HCl-Timolol Maleate PF (eye drops used to treat high eye pressure caused by glaucoma), instill one drop in the right and left eye, one time per day in the morning. Physician order was discontinued on 03/04/26. Start date of 02/23/26, Dorzolamide HCl-Timolol Maleate, instill one drop in the right and left eye, one time per day in the evening. Physician order was discontinued on 03/04/26.Start date of 03/11/26, Dorzolamide HCl-Timolol Maleate, instill one drop in the right and left eye, one time per day in the evening. Physician order was discontinued on 04/08/26. Start date of 03/12/26, Dorzolamide HCl-Timolol Maleate, instill one drop in the right and left eye, one time per day at 5:00 am. Physician order was discontinued on 04/08/26. C. Record review of R #2's medication administration record (MAR), dated 03/01/26 through 03/31/26, revealed R #1 was not administered the Dorzolamide HCl-Timolol Maleate eye drops due to an active order no longer being available. D. Record review of R #2's nursing progress notes, dated 4/28/26, revealed the Dorzolamide HCl-Timolol Maleate eye drops were discontinued on 03/05/26 by the facility without a physician's order to discontinue the eye drops. E. On 04/28/26 at 12:50 pm, during an interview, the Administrator stated R #2's eye drops did get discontinued by accident. He stated R #2's daughter was informed of the missed medication and was upset about it. The Administrator stated R #2's eye drop medication should not have been discontinued without physician authorization. F. On 04/28/26 at 2:45 pm, during an interview, Licensed Practical Nurse (LPN) #1 stated she accidently discontinued R #2's eye drops, and she did not realize the mistake for five days. The LPN #1 stated once she realized the error, she called the pharmacist, and they sent over new eye drops for R #2. G. On 04/28/26 at 1:02 pm, during an interview, the Director of Nursing (DON) stated R #2's eye drop medication should not have been discontinued by accident because there was no physician order to discontinue the medication.

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to provide treatment and care in accordance with professional standards of practice for 1 (R #1) of 1 (R #1) resident reviewed, when: The facility did not provide continuous oxygen (O2) per physician's orders due to O2 equipment failure. If the facility fails to provide O2 per physician orders, then residents may receive substandard care and treatment, placing them at risk for preventable harm.The findings are: A. Record review of R #1's face sheet revealed an admission date of [DATE] with the following diagnoses:Fracture left femur (long bone that connects the hip to the knee),Chronic obstructive pulmonary disease (COPD; lung disease),Acute respiratory failure (low oxygen levels in the blood and can damage vital organs),Pulmonary fibrosis (scarring of the lung). B. Record review of R #1's nursing progress notes, dated [DATE], indicated R #1 was sent to the emergency room (ER) due to R #1 having abnormal vital signs (body temperature, pulse rate, respiration [rate of breathing], oxygen saturation [amount of oxygen in the blood], and blood pressure). R #1 was admitted into the hospital due to her having a urinary tract infection (UTI; an infection in any part of the urinary system, which includes the kidneys, ureters, bladder, and urethra). C. Record review of R #1's hospital notes, dated [DATE], revealed the following:R #1 was diagnosed by hospital staff with Pulmonary fibrosis, Sepsis (a serious condition in which the body responds improperly to an infection), and a urinary tract infection.The hospital recommended palliative care (relieve symptoms, stress and discomfort associated with serious or chronic illness).R #1 was discharged from the hospital and back to the facility on [DATE] at 3:55 pm. D. Record review of R #1's physician orders, dated [DATE], revealed an order for O2 at 2 liters per minute continuously with a nasal cannula (a small, flexible tube that delivers oxygen to the nose through soft prongs). E. Record review of R #1's nursing progress notes, dated [DATE], revealed the following:At 4:06 pm, R #1 arrived at the facility on a stretcher while wearing 2 liters of O2. R #1 was restless and grabbing at the air. R #1 was placed in bed and an O2 concentrator (a medical device that extracts oxygen from the surrounding air, providing patients with a continuous supply of oxygen-enriched air) was put into place. The facility nurse attempted a variety of connectors for the O2 concentrator. R #1 was placed on a portable oxygen tank with a mask because the O2 concentrator was ineffective. At 4:17 pm, the facility nurse received a report on R #1 from the hospital staff. R #1 had been admitted and treated for a UTI and sepsis. R #1 was discharged back to the facility on palliative care, and R #1 was orientated to person while being restless.At 5:55 pm, R #1 was pronounced deceased by the facility Nurse Practitioner (NP). R #1 was examined at the bedside and found to be unresponsive, and breathing respirations were not observed. R #1 did not have a heart rate present. F. On [DATE] at 3:54 pm, during an interview, R #1's daughter stated once the staff got her mother in bed, they took her off the portable O2 tank provided by the ambulance staff and provided O2 with the facilities O2 concentrator. The facility O2 concentrator was not working properly, and a facility nurse went to get another O2 concentrator. R #1's daughter stated it had been a while since R #1 was on O2 while the facility staff looked for another O2 concentrator. The facility nurse brought in another O2 concentrator, but that O2 concentrator was not working either. By the time the facility nurse returned with the portable O2 tank, the NP was present next to R #1 and stated R #1 did not need the O2 because she had died. R #1's daughter stated it took the facility nurse approximately 15 minutes to bring the portable O2 tank to R #1. G. On [DATE] at 11:43 am, during an interview, with Director of Nursing (DON) stated he was not there at the time R #1 came back to the facility on [DATE], but he was called after R #1 passed. He got report from a facility nurse that R #1's family was very upset. The DON stated he asked the staff why a portable O2 tank was not in place when R #1's O2 concentrators were not working, to keep R #1 on continuous O2 per physician orders. H. On [DATE] at 12:15 pm, during an interview, the NP stated R #1 was sent back to the facility from the hospital on comfort care measures (a distinct and compassionate approach within medical care, signifying a shift in focus from attempting to cure an (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	illness to maximizing a person's quality of life). She stated R #1's death was not a surprise to anyone, and she recalled the family being very upset. She stated R #1 took her last breath when she arrived at R #1's room. She listened and checked R #1's pulse, and after a few minutes, she pronounced R #1's death. She stated R #1 was wearing O2 from a facility O2 concentrator when she saw her, but the O2 concentrator was not working properly. The NP stated she did not know how long R #1's O2 concentrator was not working, but even if R #1's O2 concentrator was working properly, it would not have changed the outcome because R #1's health was already declining.