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	02/21/2025

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. 38450 Based on observation and interview, the facility failed to maintain a homelike environment for all residents who utilized the outdoor patio located outside the main dining room when staff failed to repair water damage to the building. Failure to make repairs to maintain a homelike environment could likely cause residents to feel like they do not matter. The findings are: A. On 02/19/25 at 12:41 pm, observation of the resident's outdoor patio, located off the main dining room, revealed the fascia (the exterior framing of the roof rafters) and soffit (the finish material visible beneath the roof's overhang on a building) located to the right (facing the door from the outside) was damage, with peeling paint and exposed wood with black substance. Further observation revealed the residents utilized the area for smoking, and the damage to the building was visible to the residents. B. On 02/19/25 at 12:25 pm, during an interview, the Maintenance Director stated he was responsible to inspect and maintain the building. The Maintenance Director stated he was aware of the condition of the fascia and soffit. He stated the damage was caused by water runoff. He said he made calls to an outside company about a year ago for repairs, but he did not follow up on it. C. On 02/20/25 at 2:48 pm, during an interview, the Administrator stated he was not aware of the water damage to the fascia and soffit in the residents' outside smoking area. The Administrator stated the Maintenance Director was responsible for inspecting and maintaining the building. He stated peeling paint and exposed wood would not be considered homelike, and the resident's should not have to see the building in that condition.

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50752 Based on observations, record reviews, and interviews, the facility failed to maintain an environment that was free of potential for accidents when staff failed to: - Use footpedals when they propelled residents in their wheelchairs without the foot pedals attached for 2 (R #26 and R #3) of 2 (R #26 and R #3) residents reviewed - Maintain a resident courtyard free of sharp edges. This failure had the potential to affect all resident who utilized the enclosed courtyard. These deficient practices could likely create an unsafe situation and lead to serious injuries. The findings are: Wheelchair Foot Pedals R #26 A. Record review of R #26's current Face Sheet revealed R #26 was admitted to the facility on [DATE] with a diagnosis of muscle weakness. B. Record review of R #26's Minimum Data Set (MDS; a federally mandated assessment instrument completed by facility staff), dated 02/05/25, revealed the following: - A Brief Interview for Mental Status (BIMS; a screening for cognitive impairment) score of 11, moderately impaired. - Unable to walk 10 feet due to medical condition or safety concerns. - Dependent on staff for assistance with sitting to lying down, lying to sit on bed, chair to bed to chair transfer. - Dependent on staff with a manual wheelchair. - Had three falls since admission, two without injury and one with injury. - Took an antipsychotic, antianxiety, and antidepressant medication. - Had pain or hurting in the last five days, pain and hurt over the last five days affected his sleep. - Rated his level at a level six. (Pain rated at a scale of 00-10, with 10 the worst). (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	C. On 02/20/25 at 9:00 am during an observation, Certified Nursing Assistant (CNA) # 1 propelled R #26 in his wheelchair from the dining room to the common area. R#26 did not have any foot pedals on his wheelchair, and he held his feet up off the floor. R #26's feet fell to the ground, and the wheelchair stopped abruptly. R #26 yelled out, Damn it! CNA #1 leaned down to R #26's ear and said, Pick your feet up. CNA #1 continued to propel R #26 while the resident held his feet up off the ground. D. Record review of R #26's Occupational Therapy Evaluation and Plan of Treatment, dated 01/07/25, revealed the following: - Morbid obesity (severely overweight.) - Muscle weakness (reduction in the power exerted by muscles.) - Patient exhibits new onset of decreases in strength. - Decrease in functional mobility. (Limitation in independent purposeful physical movement.) - Reduced ability to safely ambulate (to move from place to place.) - Cognitive deficit (Intellectual disability.) - Pain and paralysis/paresis (the loss of the ability to move), placing the patient at risk for decreased ability to return to the prior living environment. - Limited functional movement. - Muscle atrophy (reduced muscle mass.) - The record did not include an evaluation of whether the resident could safely hold their legs up while staff propelled them in wheelchairs without foot pedals. - The record did not contain information to show staff discussed with the resident the use of foot pedals and the potential hazards of not using foot pedals when propelled by staff. - The record did not contain information to show the resident or their representatives chose not to use foot pedals when staff propelled them in wheelchairs. E. Record review of R #26's electronic health record, undated, revealed the following: - The record did not include an evaluation of whether the resident could safely hold their legs up while staff propelled them in wheelchairs without foot pedals. - The record did not contain information to show staff discussed with the resident the use of foot pedals and the potential hazards of not using foot pedals when propelled by staff. - The record did not contain information to show the resident or their representatives chose not to use foot pedals when staff propelled them in wheelchairs. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	F. On 02/20/25 at 10:30 am during an interview, CNA #1 stated staff asked the residents to lift their legs when they propelled the residents, because that's just how we do it. R #3 G. Record review of R #3's MDS, dated [DATE], revealed the following: - A BIMS score of 5, severe cognitive impairment. - Unable to walk 10 feet due to medical condition or safety concerns. - Had three falls since admission, two without injury and one with injury. - Had pain or hurting in the last five days, pain and hurt over the last five days affected her sleep. - Rated his level at a level four. H. On 02/20/25 at 9:22 am during an observation, CNA #1 propelled R #3 back to her room from the dining room. Further observation revealed R #3's leg dropped to the floor multiple times, and CNA #1 told R #3 to pick her legs up so they could go to the resident's room. I. Record review of R #3's Occupational Therapy Evaluation and Plan of Treatment, dated 06/15/24, revealed the following: -Dementia (a group of conditions characterized by impairment of at least two brain functions, such as memory loss and judgment.) -Muscle weakness. -Decline in function. -Fall risk. - The record did not include an evaluation of whether the resident could safely hold their legs up while staff propelled them in wheelchairs without foot pedals. - The record did not contain information to show staff discussed with the resident the use of foot pedals and the potential hazards of not using foot pedals when propelled by staff. - The record did not contain information to show the resident or their representatives chose not to use foot pedals when staff propelled them in wheelchairs. J. Record review of R #26's electronic health record, undated, revealed the following: - The record did not include an evaluation of whether the resident could safely hold their legs up while staff propelled them in wheelchairs without foot pedals. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- The record did not contain information to show staff discussed with the resident the use of foot pedals and the potential hazards of not using foot pedals when propelled by staff. - The record did not contain information to show the resident or their representatives chose not to use foot pedals when staff propelled them in wheelchairs. K. On 02/21/25 at 8:28 am and on 03/10/25 at 2:22 pm during an interview, Certified Occupational Therapy Assistant (COTA) #1 stated the Occupational Therapy (OT) staff determined if the resident was a fall risk by doing a Fall Risk Assessment. She stated the facility did not have a written policy regarding the staff propelling the residents in wheelchairs. She stated most residents did not use wheelchair pedals, because therapy staff wanted the residents to increase their mobility and independence. COTA #1 stated there was always the potential for harm when staff propelled residents in wheelchairs without foot pedals. COTA #1 stated the therapy treatment program consisted of nine approaches, and one of the approaches was wheelchair management training. She stated staff covered wheelchair management training during the resident's OT sessions. She stated proper wheelchair positioning was important. She stated the resident's hips and pelvis should be positioned at the back of the wheelchair, while their trunk and chest should be against the backrest. She stated the wheelchair armrests must be adjusted to the appropriate height for the resident, and the resident's feet should rest flat on the floor or the footrest. COTA #1 stated staff should ask the resident if they can hold their legs up when the staff member propelled the resident in the wheelchair. She stated if the resident's legs drop, then there was a risk of the resident's feet scraping the ground. She stated that could lead to injuries for the resident. L. On 02/20/25 at 2:48 pm, during an interview, the Administrator stated residents should put their feet on the foot rest and their hands in their lap when staff propel them in their wheelchairs. The Administrator stated some residents choose not to use the foot pedals on their wheelchairs, and that is their right. The Administrator stated the therapy staff evaluate the residents for the use of foot pedals on their wheel chair. The Administrator stated their is the potential for injury when staff propel residents in wheelchairs without their foot pedals. Resident Courtyard M. On 02/19/25 at 3:15 pm, observation of the residents' enclosed courtyard revealed two wooden fence pickets were not attached to two [NAME] rails, and the fence pickets had sharp points of the nails exposed. Further observation revealed a metal landscape edging touched the patio concrete, and the sharp corner of the metal [NAME] was exposed. N. On 02/19/25 at 3:17 pm during an interview, the Maintenance Director stated the residents utilized the courtyard. He stated he maintained the courtyard, but he was not aware of the sharp metal edging. He stated the sharp corner should not be exposed. The Maintenance Director stated he knew some panels on the fence were loose due to weathering, but he did not know some were not attached to two [NAME] rails. The Maintenance Director stated it was not safe to have nails exposed. O. On 02/20/25 at 2:48 pm, during an interview, the Administrator stated the Maintenance Director was responsible to inspect and maintain the residents' enclosed courtyard. The Administrator stated he was not aware of the loose fence pickets, the exposed nails, and the sharp metal edging. He stated that was not a safe environment for the residents.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 51919 Based on record review, observation, and interview, the facility failed to ensure pharmaceutical services (the direct, responsible provision of medication-related care) were met when staff failed to: -Promptly identify a loss of a controlled medication (drugs or chemicals that the government regulates because they can be easily abused and lead to addiction.) for 1 (R #26) of 1 (R #26) resident. -The Director of Nursing (DON) did not notify the facility's pharmacist consultant of the lost controlled medication timely. These deficient practices are likely to lead to a delay in the incident investigation process and lead to potential drug misuse or diversion (medical and legal concept involving the transfer of any legally prescribed controlled substance from the individual for whom it was prescribed to another person for any illicit use). The findings are: A. Record review of the facility's Controlled Medications-Administration Policy, dated 2024, revealed a physical inventory of all controlled medications should be conducted by two Licensed Nurses or one Nurse and a Certified Medication Aid (CMA), Qualified Medication Administration Personnel (QMAP), Medication Technician (Med Tech) or equivalent at each shift change and document the results on an audit record. Alternatively, the shift change audit may be recorded on the Accountability Record if there is a designated column for the audit. Any discrepancy (a lack of compatibility or similarity between two or more facts) in controlled substance medication counts should be reported to the Director of Nursing immediately. B. Record review of R #26's physician orders, dated 02/19/25, revealed R #26 received lorazepam oral tablet (antianxiety medication), 1 milligram (mg). Give one tablet by mouth three times a day at 8:00 am, 2:00 pm, and 8:00 pm for anxiety disorder. Medication was started on 08/14/24. C. Record review of R #26's Medication Administration Record (MAR), dated 02/11/25 at 7:16 am through 02/19/25 at 7:12 am, revealed staff administered a total of 25 doses of lorazepam, 1 mg to R #26, and the resident did not refuse any doses. D. Record review of R #26's Controlled Medication Accountability Record, dated 02/19/25, revealed the following: - On 02/11/25 at 5:00 am, the facility received 60 tablets of lorazepam, 1 mg. - Nursing staff administered the last dose of lorazepam to R #26 on 02/19/25 at 7:15 am. - From 02/11/25 at 7:16 am through 02/19/25 at 7:15 am, R #26 received a total of 25 scheduled doses of lorazepam oral tablet 1 mg. - A remaining balance of 35 tablets of lorazepam 1 mg. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- The record was signed and dated by CMA #1 and Nurse #1. - The record did not show the resident refused any medication. E. On 02/19/25 at 9:04 am, observation of A-hall medication cart controlled medications revealed R #26's lorazepam, 1 mg medication blister pack (transparent, molded piece of plastic, often sealed to a sheet of cardboard, used to package small items such as tablets) had a remaining balance of 34 lorazepam oral tablets. F. On 02/19/25 at 9:07 am, during an interview, CMA #1 stated she counted and compared R #26's lorazepam blister pack to R #26's Controlled Medication Accountability Record in the presence of Nurse #1, and the count matched. She stated she received the medication cart keys from the night shift nurse (Nurse #1) after they counted R #26's lorazepam together. CMA #1 stated the count matched. CMA #1 stated she kept the medication cart keys with her the whole time. G. On 03/13/25 at 11:49 am, during an interview, Nurse #1 stated she counted and compared R #26's lorazepam blister pack to R #26's Controlled Medication Accountability Record in the presence of CMA #1 at shift change, and the count matched. H. On 02/19/25 at 9:10 am and 02/21/25 at 11:00 am during an interview, the DON stated the process for reconciling (the process of comparing a patient's medication orders to all of the medications that the patient has been taking.) medications at the end of each shift was for staff to count the medications together and sign the Controlled Medication Accountability Record. The DON stated the Pharmacist conducted monthly audits and random audits. The DON stated she was not aware R #26's lorazepam blister pack was missing one tablet. She stated it was expected for CMA #1 to maintain an accurate count of R #26's lorazepam 1 mg tablets. The DON stated she should have notified the facility's consultant pharmacist within 24 hours of becoming aware of the missing medication, but she did not. I. On 02/21/25 at 10:52 am during an interview, the facility's Consultant Pharmacist (CP) stated she audited the facility's medication carts monthly and randomly. The CP stated she expected CMA #1 to count R #26's lorazepam, compare the administered and the remaining tablets, and maintain a correct count of them. She stated she expected the DON to notify her of the controlled drug incident within 24 hours of becoming aware of the missing medication, but the DON did not notify her until 02/19/25 at 1:18 pm. The Pharmacist stated she was responsible to report the missing medication to the New Mexico Board of Pharmacy within 24 hours of the incident.

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F 0800 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide each resident with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51919 Based on record review and interviews, the facility failed to provide a diet that met a resident's special dietary needs for 1 (R #249) of 1 (R #249) resident when staff failed to provide R #249 a salt free diet. This deficient practice is likely to lead to a buildup of fluid in R #249's body, causing him to have symptoms such as swelling in the legs, hands, and face, high blood pressure, shortness of breath, and potential complications like heart failure. The findings are: A. Record review of the facility's Liberalized Diets Policy, dated 2024, revealed staff were to serve residents a regular diet, unless a medical condition warranted a restricted diet. Staff were to monitor residents in relation to their conditions, their goals regarding nutritional status, and their physical, mental, and psychosocial well-being. B. Record review of R #249's electronic health record, undated, revealed R #249 was admitted to the facility on [DATE] with the following diagnoses: - Acute renal failure (sudden loss of kidney function.) - Presence of cardiac pacemaker (a device surgically implanted in the body to deliver electrical pulses to the heart to help the heartbeat in a regular rhythm.) - Ventricular tachycardia (a life-threatening, fast and abnormal heart rhythm.) - Acute respiratory failure with hypoxia (a medical condition where the lungs are unable to adequately exchange oxygen, leading to a dangerously low level of oxygen in the blood.) - Morbid obesity (severely overweight) due to excess calories. - Cardiogenic shock (a life-threatening condition that occurs when the heart is unable to pump enough blood to meet the body's needs.) C. Record review of R #249's hospital discharge paperwork, dated 02/13/25, revealed the hospital discharging physician ordered a cardiac diet (a dietary plan designed to improve heart health and reduce the risk of cardiovascular diseases). D. Record review of R #249's facility's physician orders, dated 02/13/25, revealed an admission order of regular diet. E. Record review of R #249's Care Plan, dated 02/14/25, revealed the following: - Focus: Nutritional status. The resident has a potential for alteration in nutrition related diabetes. (continued on next page)

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F 0800 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Interventions: Staff to offer the resident diet as ordered. Resident's diet was liberalized per the resident's request. F. Record review of R #249's meal ticket, dated 02/19/25, revealed the following: - Diet: Regular. - A 1500 cubic centimeter (cc) fluid restriction. - Food likes: The record did not contain any information in this area. - Food dislikes: The record did not contain any information in this area. - R #249's meal ticket did not include any food restrictions or a therapeutic diet. G. On 02/18/25 at 10:04 am, during an interview with R #249, he stated the facility staff served him a meal with bread that contained salt, and he had to return it. The resident stated he should be on a salt-free diet due to his kidney and heart issues. He stated he communicated his dietary needs to the facility's Dietary Manager when he was admitted . R #249 stated he watched the food menu every day to see if the next day's food menu contained food that was high in salt. He stated if the menu did have high sodium food then he would need to request an alternative food menu. The resident stated the Dietary Manager told him to let the kitchen staff know an hour before lunch or supper if he had specific dietary needs, and they would get him something different from the scheduled food menu. H. On 02/19/25 at 8:23 am, during an interview with the facility's Dietary Manager (DM), he stated he interviewed newly admitted residents and talked to them about the liberalized diets. The DM stated R #249 told him (DM) about his (the resident's) diet restrictions during the initial interview. The DM stated R #249 needed to be on a salt-free diet, and he should have that information to R #249's meal ticket under the Food Dislikes section. I. On 02/20/25 at 9:21 am, during an interview with the facility's Registered Dietician (RD), she stated the facility offered a liberalized diet to all residents to provide a homelike environment and to allow residents to eat what they liked. The RD stated she expected the Dietary Manager to add bread to R #249's meal ticket under the Food Dislikes section, so kitchen staff would not add it to his meal. J. On 02/21/25 at 9:30 am, during an interview with the facility's Medical Director (MD), he stated the facility's management tried different specialized diets in the past, and they noticed residents still brought food and snacks from outside. The MD stated residents considered the facility their home, and they should be able to eat what they liked. He stated the facility provided a healthy and balanced diet to all residents, and the liberalized diet was appropriate for a large number of residents. The MD stated it was expected the facility take residents' and their representatives' input in regards to food and any changes they wanted in their diet. He stated he expected the facility's RD to review R #249's diet needs and made sure the resident's diet did not contain salt.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 50752 Based on observation and interview, the facility failed to maintain the kitchen in a sanitary manner for all residents who received food or drinks in the facility when staff failed to: - Keep the kitchen dust and grime free. - Ensure the ice machine drained through an air gap. These failures had the potential to result in cross-contamination and foodborne illness which could affect all residents who ate food from the kitchen. The findings are: Dust A. On 02/17/25 at 12:25 pm, observation of the kitchen revealed the following: - The wall and ceiling above the food preparation area were visibly dusty. - The deep fry area had visible dust and grime on it. - Vents near the food preparation area had dust and grime. - The kitchen staff prepared the residents' lunches below the visibly dusty ceiling. B. On 02/21/25 at 10:08 am, during an interview, the Dietary Supervisor (DS) stated staff should wash down the walls and ceiling to make sure that there was not any contamination. The DS stated it was over a year since staff washed down the walls and ceiling. The DS stated the deep fry area should be cleaned daily, but it did not look like it was done. The DS stated maintenance staff was supposed to clean the ceiling vents, but the DS was unsure when they were done. C. On 02/21/25 at 10:10 am, during an interview, the Director of Maintenance (DOM) stated the last time he cleaned the vents in the kitchen was last year. The DOM stated he did not document when he cleaned the vents. Ice Machine D. On 02/19/25 at 3:52 pm, observation of the therapy kitchen revealed the ice machine did not drain through an air gap. The ice machine drained into a pump, and the pump drained directly into the waste water pipe. Further observation revealed the ice machine contained ice, and staff used the ice for the residents. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	E. On 02/19/25 at 3:55 pm during an interview, the Director of Maintenance stated the ice machines should drain through an air gap so the waste water did not backup into the ice machine drain pipes. He stated this could cause bacteria to grow into the pipe and contaminate the ice. The DOM stated he was aware the ice machine in the therapy kitchen did not drain through an air gap. He stated he thought this was okay since the ice machine drained into a pump. The DOM did not know if the pump had a backflow preventer, and he did not know if the pump prevented bacteria from entering the ice machine drain pipe. F. On 02/20/25 at 2:48 pm during an interview with the Administrator and the DOM, the Administrator stated the DOM was responsible to inspect and maintain the ice machines in the facility. The Administrator stated the DOM inspects the ice machines every three months to ensure there was not a buildup of scale and lime and to ensure the drain was clear. The Administrator and the DOM stated the ice machine should drain through an air gap to prevent the growth of bacteria.