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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION               | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>325120 | (X2) MULTIPLE CONSTRUCTION<br>A. Building<br>B. Wing                                      | (X3) DATE SURVEY COMPLETED<br><br>01/24/2025 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Fort Bayard Medical Center |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>41 Fort Bayard Road<br>Santa Clara, NM 88026 |  |

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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)  |
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| <p>F 0604</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment.</p> <p>41755</p> <p>THIS IS A REPEAT DEFICIENCY FROM 08/09/24</p> <p>Based on observation, record review and interview, the facility failed to ensure residents were free from physical restraints unless being used to treat a specific medical condition (indication or characteristic of a medical, physical or psychological condition) as identified through an assessment for 3 (R #1, R #2, and R #8) of 3 (R #1, R #2, and R #8) reviewed for physical restraints. This deficient practice could likely result in physical restraints being used for staff convenience; unnecessarily preventing residents from freedom, movement, and/or activity. The findings are:</p> <p>A. Record review of a complaint dated 12/24/24, an anonymous staff member revealed the facility had removed alarms for residents after the last survey and then they started using bed alarms again for residents without conducting an assessment or having a physician's order.</p> <p>R #1</p> <p>B. On 01/23/25 at 5:14 PM, during an observation of R #1, revealed R #1 had an alarm attached to her wheelchair.</p> <p>C. On 01/23/25 at 5:14 PM, during an interview, CNA #1 confirmed R #1 had a wheelchair alarm attached to her wheelchair.</p> <p>D. On 01/24/25 at 12:06 PM, during an observation of R #1, revealed R #1 had an alarm attached to her wheelchair.</p> <p>E. On 01/24/25 at 12:06 PM, during an interview, RN # 1 confirmed the alarm attached to R #1's wheelchair was actually a seat belt alarm and not a wheelchair alarm.</p> <p>F. Record review of R #1's medical record (electronic and paper chart) revealed the following:</p> <ol style="list-style-type: none"> <li>1. The record did not contain a physician's order for a seat belt alarm.</li> <li>2. The record did not contain any assessments to indicate that R #1 needed a seat belt alarm.</li> </ol> <p>(continued on next page)</p> |

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.

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| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| <p>F 0604</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>                     | <p>G. On 01/24/25 at 2:24 PM, during an interview, doctor #1 stated he had not been consulted regarding any alarms for R #1.</p> <p>H. On 01/24/25 at 3:10 PM, during an interview, the DON stated R #1 did not have an order in place for a seat belt alarm, and an assessment has not been completed to identify a specific need for a seatbelt alarm.</p> <p>R#2</p> <p>I. On 01/23/25 at 5:16 PM, during an observation of R #2, revealed R #2 had an alarm on her wheelchair.</p> <p>J. On 01/24/25 at 12:00 PM, during an observation of R #2's room, revealed R #2 had a bed alarm.</p> <p>K. On 01/24/25 at 12:00 PM, during an interview, RN #1 confirmed R #2 had a bed alarm.</p> <p>L. On 01/24/25 at 12:04 PM, during an interview, RN #2 confirmed R #2 had a seatbelt alarm attached to her wheelchair.</p> <p>M. Record review of R #2's medical record (electronic and paper chart) revealed the following:</p> <ol style="list-style-type: none"> <li>1. Verbal order dated 10/08/24: Continue with seatbelt with alarm and bed alarm.</li> <li>2. The record did not contain any assessments to indicate that R #2 needed a seat belt alarm and a bed alarm for a specific medical condition.</li> </ol> <p>R #8</p> <p>N. On 01/23/25 at 4:00 PM, during an observation of R #8, revealed R #8 had an seatbelt alarm on her wheelchair.</p> <p>O. On 01/23/25 at 4:14 PM, during an interview, RN #3 confirmed R #8 had a seatbelt alarm attached to her wheelchair.</p> <p>P. Record review of R #8's medical record (electronic and paper chart) revealed the record did not contain any assessments to identify a need for a seat belt alarm for R #8.</p> <p>Q. On 01/24/25 at 2:23 PM, during an interview, DR #1 said he had never been asked for a restraint order to identify the need for wheelchair or seat belt alarms.</p> <p>R. On 01/24/25 at 11:57 pm, during an observation of the E unit, revealed staff were removing alarms from residents' rooms.</p> <p>S. Record review of a complaint received on 01/27/25 revealed an anonymous staff member reported that staff were told to remove a bed alarm because surveyors were in the facility verifying alarms.</p> <p>(continued on next page)</p> |   |  |

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| <p>F 0604</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>                     | <p>T. On 02/10/25 at 12:03 PM, during an interview, the Administrator said alarms were not removed while the surveyors were at the facility. The Administrator said that an assessment would have to be done before any alarms were removed. The Administrator further stated not all of the residents were assessed for alarms by the time the revisit was done on 10/30/24 because completing an assessment takes time (plan of correction completion date was 09/23/25). Administrator said it would not be safe or smart to go in and remove everything [alarms] without assessments. The Administrator said the target date to have the assessments done was is April 2025.</p> <p>47510</p> |   |  |

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| <p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>                     | <p>Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.</p> <p>41755</p> <p>Based on record review, observation, and interview, the facility failed to ensure care plans were reviewed and revised for 1 (R #1) of 3 (R #1, R #2, and R #8) residents reviewed for care plans when they failed to revise the care plan with the most current resident information. This deficient practice could likely result in the care plan not being updated with the most current resident conditions and appropriate interventions, 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:</p> <p>A. On 01/23/25 at 5:14 PM an observation of R #1 revealed R #1 had an alarm attached to her wheelchair.</p> <p>B. On 01/23/25 at 5:14 PM, during an interview with CNA # 1, revealed the following:</p> <ol style="list-style-type: none"> <li>1. CNA #1 stated R #1 did not have any alarms because they had been discontinued.</li> <li>2. CNA #1 then made an observation of R #1 and stated R #1 had a wheelchair alarm.</li> </ol> <p>C. On 01/24/25 at 12:06 PM, during an interview, RN # 1 confirmed that the alarm attached to R #1's wheelchair was actually a seat belt alarm and not a wheelchair alarm.</p> <p>D. Record review of R #1's care plan (initiated 10/30/23) revealed the following:</p> <ol style="list-style-type: none"> <li>1. R #1 was at risk for falls.</li> <li>2. Bathroom door alarm, bed and wheelchair alarms. Check for proper function at least every shift and as needed.</li> </ol> <p>E. On 01/24/25 at 3:53 PM, during an interview, the DON confirmed that R #1's care plan had not been updated to reflect that R #1 no longer had a door alarm, bed alarm, and wheelchair alarm.</p> |   |  |