

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 325120	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/09/2024
NAME OF PROVIDER OR SUPPLIER Fort Bayard Medical Center		STREET ADDRESS, CITY, STATE, ZIP CODE 41 Fort Bayard Road 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.

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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>47510</p> <p>Based on record reviews, observations and interviews, the facility failed to treat resident with dignity when staff failed to:</p> <ol style="list-style-type: none"> 1. Provide nondisposable cutlery and dishware to all 75 residents, who did not use adaptive equipment were not on enteral feeding tube (a medical device used to provide nutrition to people who cannot obtain nutrition by mouth) (residents were identified by the adaptive equipment list provided by the Administrator on 08/13/24 and the resident matrix provided by the Administrator on 08/05/24), and 2. Let R #98 self-determine (choice) her use of a belt alarm (an alarm for a wheelchair). <p>These deficient practices could likely cause residents to feel anxious or depressed and like they are not valued. The findings are:</p> <p>Use of Disposable Dishware and Cutlery</p> <p>A. On 08/06/24 at 12:28 PM, during an observation of the D Unit's lunch service, the residents were served meals on disposable plates and given disposable cups for drinks.</p> <p>B. On 08/06/24 at 12:30 PM, during an observation, residents in the memory care main dining area, residents ate with disposable plates, plastic utensils, and disposable cups.</p> <p>C. On 08/06/24 at 12:37 PM, during a lunch observation of the main dining room, residents used plastic utensils, Styrofoam cups, and Styrofoam plates.</p> <p>D. On 08/06/24 at 12:39 PM, during an interview, CNA #11 confirmed that the residents have been using disposable cutlery and dishware for about a year.</p> <p>E. On 08/06/24 at 12:40 PM, during an observation of the dining area at the end of C 100-105 Hall in the memory care, residents ate on disposable plates, used plastic utensils, and used disposable cups.</p> <p>F. On 08/06/24 at 12:45 PM, during an interview, R #36 said they (residents) had been using disposable dishes for a long time. R #36 said it makes her feel like she is in camp.</p> <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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>G. On 08/06/24 at 12:50 PM, during an observation of the main dining area, residents ate with disposable plates, used plastic utensils, and used disposable cups.</p> <p>H. On 08/06 /24 at 12:50 PM during an interview with R #71, when asked R #71 what eating utensils she preferred, she stated she preferred the metal utensils, but they have been using the plastic ones for awhile because the dishwasher is broken.</p> <p>I. On 08/06/24 at 12:53 PM, during an interview, R #49 said she lost track of how long they have been eating on disposable dinnerware, she said it had been at least a year. R #49 said it is difficult to cut meat on paper plates and with a plastic knife. R #49 said that she cuts through her plate sometimes.</p> <p>J. On 08/06/24 12:54 PM during an interview, R #21 was asked her preference in eating utensils R #21 stated, she prefers silverware, but we have been using plasticware for some time.</p> <p>K. On 08/06/24 at 12:58 PM, during an interview, the Dietary Manager #11 said the dishwasher had not been working since October 2023. DM #11 said they are waiting on a vendor. DM #11 said that they have been using disposable dinnerware since October 2023.</p> <p>L. On 08/06/24 at 1:03 PM, during an interview, R #13 said that the dishwasher has been broken for a year. R #13 said that it is hard to cut with plastic knives. R #13 said that staff can cut his food for him, but it takes away from his independence.</p> <p>M. On 08/07/24 3:00 PM, during an interview with Dietary Manager, she stated the dishwasher was working; however, was not maintaining the proper temperature.</p> <p>Belt Alarm</p> <p>R #98</p> <p>N. On 08/07/24 at 10:40 AM, during an observation, R #98 had a lap belt with an alarm while she sat in her wheelchair.</p> <p>O. Record review of R #98's physician's orders revealed R #98 did not have a belt alarm order.</p> <p>P. Record review of R #98's care plan dated 04/26/24 revealed R #98 had a lap belt for being a fall risk.</p> <p>Q. On 08/07/24 at 10:42 AM, during an interview with R #98, she said she could remove the lap belt and demonstrated that she could do so; the alarm went off when she unbuckled it. R #98 said the alarm is loud, and she doesn't like it. R #98 said that it embarrass her when the alarm goes off. R #98 said she tried to take it off and put the belt behind her, but the staff would come and put it back around her.</p> <p>49313</p> <p>49827</p>		

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<p>F 0582</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered.</p> <p>50497</p> <p>Based on record review of the CMS-10055 Form and interview, the facility failed to inform residents when changes in coverage were made to items and services covered by Medicare and/or by Medicaid for 1 (R #9) of 3 (R #9, R #31, and R #256) residents reviewed for beneficiary notices when staff failed to provide R #9 with Form CMS-10055- Skilled Nursing Facility (SNF) Advanced Beneficiary Notice (ABN) of Non-Coverage [form used to inform the beneficiary (resident) about potential non-coverage and the option to continue services with the beneficiary accepting financial liability for those services.] This deficient practice can likely confuse the resident or their representative as to what services they receive or do not have financial coverage for under Medicare and/or Medicaid. The findings are:</p> <p>R #9</p> <p>A. Record review of the CMS-10055 form for R #9's revealed the form was not completed or given to R #9 prior to services ending on 07/15/24.</p> <p>B. On 08/07/24 at 4:15 PM, during an interview with the Office Manager (OM), she stated R #9's beneficiary notification was not completed because she was out sick with Covid-19, her back up was out, and her supervisor was out. She stated the beneficiary notification form was not provided to R #9 prior to 07/15/24.</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>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.</p> <p>47510</p> <p>Based on observations and interviews, the facility failed to provide a homelike environment with comfortable sound levels for 3 (R #73, R #86, and R #99) of 3 (R #73, R #86, and R #99) residents reviewed for homelike environment. This deficient practice could likely cause residents to feel anxious or depressed and feel that they are not valued. The findings are:</p> <p>A. On 08/06/24 at 9:48 AM, during an observation of the D Unit, a loud sound could be heard down the hall, five doors away from the room where the sound was coming from.</p> <p>B. On 08/06/24 at 9:50 AM, during an interview with CNA #21, stated the following</p> <ol style="list-style-type: none"> 1. The loud sound was a bathroom door alarm. 2. The bathroom alarms are set off when the bathroom door is opened and will turn off when the door is closed so they know when someone who is a fall risk goes into the bathroom. 3. Every new resident gets a bed, chair, and bathroom door alarm until the staff assesses the resident for fall risk. <p>C. On 08/06/24 at 9:54 AM, during an interview with Unit Manager #21, confirmed the following:</p> <ol style="list-style-type: none"> 1. Bed alarms, chair alarms, and bathroom door alarms are loud and can be heard from the end of the hall to the nurses' station at the other end of the hall. 2. Bed alarms make noise, blink above the resident's door, and blink at the nurses' station. 3. Bed alarms are very sensitive and loud and sometimes make noise when a resident repositions. 4. Every resident upon admission, gets a chair, bed, and bathroom door alarm. 5. Nursing, therapy, and physicians assess the resident for the need for alarms and will remove them if the team determines the resident is not at risk for falls. <p>D. On 08/07/24 at 9:32 AM through 9:41 AM, during an observation of the main hallway and the main common area, revealed the following:</p> <ol style="list-style-type: none"> 1. The Secure Unit entrance door alarm was audible (could be heard) by the entrance to the D Unit, which was down a long hallway, around a corner, and down another long hallway. 2. At 9:33 AM, the Secure Unit entrance door alarm was audible in the main dining room, which was down a long hallway and around a corner from the secure unit. 3. At 9:33 AM, the Secure Unit entrance door alarm was audible in the main dining room when a staff member entered the Secure Unit within the same minute. <p>(continued on next page)</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>4. At 9:35 AM, the Secure Unit entrance door alarm was audible in the common area/TV/Sitting area near the gift shop, which was down a long hallway from the Secure Unit, when a staff member exited the Secure Unit.</p> <p>5. At 9:37 AM, the Secure Unit entrance door alarm was audible in the common area/TV/Sitting area near the gift shop when a staff member entered the Secure Unit.</p> <p>6. At 9:37 AM, the Secure Unit entrance door alarm was audible in the common area/TV/Sitting area near the gift shop when another staff member entered the Secure Unit within the same minute.</p> <p>7. At 9:41 AM, the Secure Unit entrance door alarm was audible at the entrance to the E Unit, which was down a long hallway away from the Secure Unit, when a staff member exited the Secure Unit.</p> <p>E. On 08/07/24 at 9:50 AM, during an interview with CNA #22, she stated the following:</p> <ol style="list-style-type: none"> 1. Several residents, including R #73 and R #86, have stated that the bed alarms, chair alarms, and bathroom door alarms are too loud. 2. The bed alarms constantly make noise at night when the residents move. 3. R #73 and R #86 get upset because another resident's bed alarm and door alarm are too loud and frequently make noise. <p>R #73</p> <p>F. On 08/07/24 at 10:05 AM, during an observation of R #73's room and an interview, R #73 stated the following:</p> <ol style="list-style-type: none"> 1. The alarm for the resident across the hall frequently makes a noise at night. 2. The noise makes it hard to sleep because it is too loud. 3. The alarm makes noise two to three times every night. 4. During the interview an alarm sounded loudly from a room across the hall from R #73 room. 5. R #73 said that a door alarm made the noise that could be heard. <p>G. On 08/07/24 at 10:15 AM, during an interview with CNA #22, confirmed the following:</p> <ol style="list-style-type: none"> 1. The sound heard during the interview with R #73 was from the bathroom door alarm in a room across the hall from R #73. 2. Housekeeping was cleaning the bathroom, and the bathroom door alarm made a noise while the door is open. <p>R #86</p> <p>(continued on next page)</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>H. On 08/07/24 at 11:18 AM, during an interview with R #86, stated the following:</p> <ol style="list-style-type: none"> 1. The bed alarm for a resident across the hall makes noise about two to three times a week during the night. 2. The same resident's bathroom door alarm also makes noise but not as frequently as the bed alarm. 3. The alarms are loud. 4. He has told staff (R #86 did not specify which staff or when he told staff) that the noises bother him. <p>3. The facility has not done anything about the noise.</p> <p>R#99</p> <p>I. On 08/05/24 at 12:33 PM, during an observation of the secured unit, R #99 was observed to have covered his ears when the entry door to the secured unit alarm would go off whenever someone entered or exited the unit.</p> <p>J. On 08/07/24 at 10:50 AM, during an interview with RN #11, she said that the alarm on the entry door to the secured unit is very loud, but you get use to it after a while. RN #11 said that if you hear the alarm, it means the door is unlocked. RN #11 confirmed that R #99 covers his ears when he hears the alarm on the entry door to the secured unit.</p> <p>49313</p>		

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<p>F 0604</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment.</p> <p>47510</p> <p>Based on observations, record reviews and interviews the facility failed to keep residents free from physical restraints for 5 (R #30, R #34, R #45, R #82 and R #98) of 5 (R #30, R #34, R #45, R #82 and R #98) residents reviewed for physical restraints, when staff used the following:</p> <ol style="list-style-type: none"> 1. Wheelchair alarms on R #30, R #82, and R #98 2. Bed alarms on R #30, R #34, R #82, and R #98 3. Bathroom alarms on R #30, R #45, and R #98 <p>These deficient practices could likely result in physical restraints being used for discipline or staff convenience; unnecessarily preventing residents from freedom, movement, or activity. The findings are:</p> <p>A. On 08/06/24 at 9:50 AM, during an interview with CNA #21, he revealed that every newly admitted resident gets a bed, chair, and bathroom door alarm until the resident is assessed for fall risk.</p> <p>B. On 08/06/24 at 9:54 AM, during an interview with Unit Manager #21, confirmed the following:</p> <ol style="list-style-type: none"> 1. Every resident who is admitted gets a chair alarm, bed alarm, and bathroom door alarm. 2. Nursing, therapy, and the physicians assess the resident for the need for alarms and will remove them if the team determines the resident is not at risk for falls. <p>R #30</p> <p>C. On 08/06/24 at 3:08 PM, during an observation of R #30's room, R #30 had an alarm on her wheelchair, bed, and bathroom door.</p> <p>D. Record review of R #30's medical record revealed the following:</p> <ol style="list-style-type: none"> 1. The record did not contain a physician's order for the wheelchair, bed, and bathroom alarm. 2. The record did not contain any assessments that R #30 needed an alarm for the wheelchair, bed and bathroom. <p>R #34</p> <p>E. On 08/06/24 at 11:57 AM, during an observation of R #34's room, R #34 had an alarm on her bed.</p> <p>F. Record review of R #34's medical record revealed the following:</p> <ol style="list-style-type: none"> 1. The record did not contain a physician's order for the bed alarm. <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 - Some</p>	<p>2. The record did not contain any assessments that R #34 needed a bed alarm.</p> <p>R #45</p> <p>G. On 08/06/24 at 3:19 PM, during an observation of R #45's room, R #45 had an alarm on her bathroom door.</p> <p>H. Record review of R #45's medical record revealed the following:</p> <ol style="list-style-type: none"> 1. The record did not contain a physician's order for the bathroom door alarm. 2. The record did not contain any assessments that R #45 needed a bathroom door alarm. <p>R #82</p> <p>I. On 08/06/24 at 3:24 PM, during an observation, R #82 had an alarm on her bed and wheelchair.</p> <p>J. Record review of R #82's medical record revealed the following:</p> <ol style="list-style-type: none"> 1. The record did not contain a physician's order for the bed and wheelchair alarm. 2. The record did not contain any assessments that R #82 needed an alarm for the wheelchair and bed. <p>R #98</p> <p>K. On 08/06/24 at 1:55 PM, during an interview with R #98's daughter, she said that R #98 currently has a wheelchair, bed, and bathroom alarm.</p> <p>L. Record review of R #98's medical record revealed the following:</p> <ol style="list-style-type: none"> 1. The record did not contain a physician's order for the wheelchair, bed, and bathroom alarm. 2. The record did not contain any assessments that R #98 needed the wheelchair, bed, and bathroom alarms. <p>M. On 08/08/24 at 11:35 AM, during an interview with the DON, she said that they use the alarms when all new resident are admitted . The DON continued to state that the facility will evaluate if the alarms are needed after the resident has been at the facility and has become familiar with their surroundings.</p> <p>49313</p>		

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<p>F 0655</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41755</p> <p>Based on record reviews and interview, the facility failed to create an accurate baseline care plan (minimum healthcare information necessary to provide effective and person-centered care immediately upon their admission to the facility) within 48 hours of admission for 1 (R #103) of 2 (R #103 and R #104) 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:</p> <p>A. Record review of R #103's admission record no date revealed R #103 was admitted into the facility on [DATE].</p> <p>B. Record review of R #103's physician's order revealed an order date 05/13/24, Do Not Resuscitate (DNR; a legally recognized order signed by a physician at a patient's request, stating the resident does not want to be resuscitated if they suddenly go into cardiac arrest or stop breathing)</p> <p>C. Record review of R #103's medical record revealed the admission care plan, dated 05/13/24, revealed staff did not include the physician's order for R #103's DNR status.</p> <p>D. On 08/09/24 at 12:33 PM, during an interview with the DON, she confirmed R #1's admission care plan did not include R #103's DNR order.</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>47510</p> <p>Based on observation, record review, and interview, the facility failed to ensure care plan revision occurred for 6 (R #30, R #34, R #35, R #45, R #82, and R #98) of 6 (R #30, R #34, R #35, R #45, R #82, and R #98) residents reviewed for care plans, when they failed to:</p> <ol style="list-style-type: none"> 1. Update R #30, R #34, R #45, R #82, and R #98's care plans for intervention for the wheelchair, bed, and bathroom alarms. 2. Update R #35's care plan for removal of bed alarm. <p>These deficient practices 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>R #30</p> <p>A. On 08/06/24 at 3:08 PM, during an observation of R #30's room, R #30 had an alarm on her wheelchair, bed, and bathroom door.</p> <p>B. Record review of R #30's care plan dated 10/11/23 revealed the care plan did not contain any interventions for wheelchair, bed, and bathroom door alarms.</p> <p>R #34</p> <p>C. On 08/06/24 at 11:57 AM, during an observation of R #34's room, R #34 had an alarm on her bed.</p> <p>D. Record review of R #34's care plan dated 08/30/23 revealed the care plan did not contain any interventions for bed alarms.</p> <p>R #35</p> <p>E. Record review of R #35's care plan dated 07/05/24 under functional abilities section revealed the following:</p> <ol style="list-style-type: none"> 1. R #35 had a bed alarm documented with bilateral half side (one of two equal parts that together make up the whole number, amount or object) rails. <p>F. On 08/09/24 at 1:29 PM during an interview with the DON she confirmed the following:</p> <ol style="list-style-type: none"> 1. R #35 does not need a bed alarm. 2. The MDS assessment does not have use for bed rails, and no bed alarm documented either. <p>(continued on next page)</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>3. The care plan was updated to show any changes</p> <p>G. On 08/09/24 at 1:49 PM, during an interview with the MDS coordinator she confirmed the following:</p> <ol style="list-style-type: none"> 1. R #35 does not have a bed alarm 2. R #35 has never needed one. 3. R #35 care plan was updated, and the bed alarm was removed. <p>R #45</p> <p>H. On 08/06/24 at 3:19 PM, during an observation of R #45's room, R #45 had an alarm on her bathroom door.</p> <p>I. Record review of R #45's care plan dated 02/03/22 revealed the care plan did not contain any interventions for the bathroom door alarm.</p> <p>R #82</p> <p>J. On 08/06/24 at 3:24 PM, during an observation of R #82 room, R #82 had an alarm on her bed and wheelchair.</p> <p>K. Record review of R #82's care plan dated 02/03/22 revealed the care plan did not contain any interventions for bed and wheelchair alarms.</p> <p>R #98</p> <p>L. On 08/06/24 at 1:55 PM, during an interview with R #98's daughter, she said that R #98 had a wheelchair, bed, and bathroom door alarm.</p> <p>M. Record review of R #98's care plan dated 04/18/24 revealed the care plan did not contain any interventions for the wheelchair, bed and bathroom door alarms.</p> <p>50497</p>		

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NAME OF PROVIDER OR SUPPLIER Fort Bayard Medical Center		STREET ADDRESS, CITY, STATE, ZIP CODE 41 Fort Bayard Road Santa Clara, NM 88026	
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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide enough food/fluids to maintain a resident's health.</p> <p>49313</p> <p>Based on interview and record review, the facility failed to maintain acceptable parameters of nutritional status, such as usual body weight for 1 (R #14) of 2 (R #25 and R #62) residents sampled for nutrition, when staff failed to follow protocols for identifying weight loss when R #14 had severe weight loss. This deficient practice could likely result in residents losing weight without the facility being aware causing physical and mental health issues. The findings are:</p> <p>A. Record review of R #14's medical record revealed the following diagnoses:</p> <ol style="list-style-type: none"> 1. Tourette's Disorder (a disorder that involves repetitive movements or unwanted sounds (tics) that can't be easily controlled). 2. Paranoid Schizophrenia (a type of schizophrenia accompanied by paranoia. Delusions and hallucinations are the two symptoms). 3. Major Depressive Disorder (A mental health disorder characterized by persistently depressed mood or loss of interest in activities, causing significant impairment in daily life). 4. Hyperlipidemia (A condition in which there are high levels of fat particles (lipids) in the blood) 5. Dysphagia (difficulty swallowing). 6. Chronic Kidney Disease, Stage 2 (damage to the kidneys is mild). <p>B. Record review of R #14's care plan, dated 05/23/16, revealed the following:</p> <ol style="list-style-type: none"> 1. R #14 was at risk of nutritional decline. 2. R #14 will not have significant weight changes indicated by 5% weight change in 1 month, 7.5% weight change in 3 months, or 10% weight change in 6 months. 3. Weigh R #14 at the same time of day, with the same scale, and in similar clothing. 4. Adjust R #14's nutritional plan as needed. <p>C. Record review of R #14's recent weights logs revealed the following:</p> <ol style="list-style-type: none"> 1. On 07/02/2024, R #14 weighed 160.8 pounds. 2. On 08/01/2024, R #14 weighed 150.0 pounds. 3. R #14 had an equivalent of a 6.72 % weight loss in one month (severe weight loss is greater than 5% in one month). <p>(continued on next page)</p>		

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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>D. On 08/06/24 at 12:48 PM, during an observation of the lunch meal, R #14 told staff he did not want food and requested a supplement drink instead, which staff provide.</p> <p>E. Record review of R #14's provider progress note, dated 08/04/24, revealed R #14 had a 5% weight change and that R #14's appetite was satisfactory, with no significant weight loss (significant loss is 5% in one month).</p> <p>F. Record review of R #14's physician's orders, no date, revealed the orders did not contain that R #14 was to receive nutritional supplements or any other interventions for R #14's weight loss.</p> <p>G. On 08/08/24 at 11:24 AM, during an interview with Unit Manager (UM) #21, stated the following:</p> <ol style="list-style-type: none"> 1. Weights are monitored by restorative nursing staff (RNA) at the beginning of each month. 2. If a resident's weight changes, RNA's show the nurse or unit manager the sheet with the weight and usually have them sign off that they saw it. 3. UM #21 was unsure where RNA's would document that they notified staff of resident weight change. 4. Each unit has a Risk Team meeting (meeting for interdisciplinary team members to discuss residents who have potential risks) every two weeks. 5. During the Risk Team meeting, they discuss residents with weight changes. <p>H. Record review of R #14's Risk Meeting notes, dated 08/08/24, revealed that during the Risk Meeting R #14's weight loss was not discussed.</p> <p>I. On 08/09/24 at 11:33 AM, during an interview with RNA #21, stated the following:</p> <ol style="list-style-type: none"> 1. RNAs obtain weights for all residents at the beginning of the month. 2. If residents' weights change by more than 5-pounds, RNAs are supposed to report the change to the nurse or the unit manager. 3. RNAs enter resident weights into the computer and keep a paper copy of the weights. 4. RNAs do not document if they notified the nurse or unit manager. 5. RNA #21 confirmed that her paper copy of R #14's weights indicated that R #14 had an 11-pound weight loss. 6. RNA #21 confirmed that the nurse or unit manager should have been notified about R #14's weight loss. 7. RNA #21 could not determine if nursing staff were notified about R #14's weight change. <p>J. On 08/09/24 at 12:02 PM, during an interview with RN #21, she stated the following:</p> <p>(continued on next page)</p>		

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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<ol style="list-style-type: none"> 1. Nursing staff should have been made aware of R #14's weight loss. 2. RN #21 was unable to find documentation that nursing staff were made aware of R #14's significant weight loss. 3. RN #21 confirmed that there were no changes to R #14's orders for nutrition since his weight loss on 08/01/24. 4. RN #21 was aware that R #14 had not been eating as much (was unsure how long). 5. RN #21 was unaware that R #14 had lost weight. 6. RN #21 stated if she had been notified about R #14's weight change, she would have notified the provider and entered any orders. 7. There was no documentation in the non-emergent provider notification book (binder that staff use to notify providers about non-emergent situations) about R #14's weight loss. <p>K. Record review of R #14's nutrition log for July 2024, revealed the following:</p> <ol style="list-style-type: none"> 1. R #14 refused 21 meals. 2. R #14 ate 0-25% of his meal three times. <p>L. On 08/09/24 at 1:16 PM, during an interview with the DON, she stated the following:</p> <ol style="list-style-type: none"> 1. R #14 had a 10.8-pound weight loss from July to August 2024. 2. The facility recognizes a weight loss of 5% or greater as a significant weight loss. 3. The expectation is for RNA to reweigh the resident. If there is a 5-pound weight change, then alert the nurse or nurse manager. 4. She was unable to determine if R #14 was reweighed. 6. She was unable to determine if the RNA notified the nurse about R #14's weight loss. 6. Nurses are expected to notify the provider about significant weight changes and enter any orders received. 7. Nutrition concerns should be discussed during the unit Risk Meeting. 8. R #14's unit had a Risk Meeting on 08/08/24. 9. During the Risk Meeting on 08/08/24, staff did not discuss R #14's weight loss. 10. R #14 did not have any interventions in place for nutrition concerns.

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<p>F 0700</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50497</p> <p>Based on observation, record review, and interview, the facility failed to ensure resident was assessed for risk of entrapment (state of being stuck or caught on bed rail) from bed rails for 1 (R #35) of 1 (R #35) resident reviewed for accidents. This deficient practice has the potential to cause serious injury by becoming trapped between the mattress and bed rail. The findings are:</p> <p>R #35</p> <p>A. Record review of R #35's admission record revealed she was admitted to facility on 10/21/14.</p> <p>B. On 08/07/24 at 11:32 AM, during an observation of R #35's bed, the bed had bilateral half side rails.</p> <p>C. Record review of R #35's nursing progress note dated 09/15/2015 (document provided by the facility) revealed the following:</p> <ol style="list-style-type: none"> 1. R #35 bed has two half side rails. 2. R #35's side rails are not considered restraints as [Name of R #35] is in comatose (being in a coma, unconscious or unable to communicate for a prolonged or indefinite period) condition with no voluntary movement. D. Record review of R #35's medical record revealed R #35 has not been assessed by a physician for the half bed rails since 10/21/14 and there were no current physician orders for the half bed rails. E. Record review of R #35's MDS assessment dated [DATE] under Section P Restraints and alarms P0100 revealed bed rails are not marked for use. F. On 08/09/24 at 1:11 PM, during an interview with physical therapist #31 (PT), he stated he has not been asked to assess R #35 for the bed rails since he has worked at the facility (no date provided). G. Record review of the nurse bed rail assessments revealed the following: <ol style="list-style-type: none"> 1. R #35's nursing bed rail assessment was completed on 03/09/24. 2. R #35's nursing bed rail assessment was completed on 06/24/24. 3. R #35 is immobile. 4. Reason the side rail is being used is marked as Not Applicable (NA). <p>(continued on next page)</p>		

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<p>F 0700</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>5. R #35 head of the bed need to be up for care (this increases the risk of entrapment) marked yes.</p> <p>H. On 08/09/24 at 1:29 PM, during an interview with the DON, she stated the following:</p> <ol style="list-style-type: none"> 1. R #35 MDS assessment dated [DATE] does not have use for bed rails marked. 2. Nurses have completed the bed rail assessments (carried out by a competent person considering the bed occupant, assessing the rail is suitable for use) for R #35 quarterly. 3. Bed rail assessments from PT or Occupational Therapy (OT) cannot be confirmed to be done for R #35. <p>I. On 08/09/24 at 1:49 PM, during an interview with the MDS Coordinator (MDSC), she stated R #35 half side bed rails are not considered a restraint (are any manual method or physical or mechanical device, material or equipment attached or adjacent to the resident's body that the individual cannot remove easily which restricts freedom of movement or normal access to one's body), so she did not code them on the MDS, but they are care planned for.</p>		

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<p>F 0732</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Post nurse staffing information every day.</p> <p>49827</p> <p>Based on observation and interview, the facility failed to post nurse staffing data on a daily basis for all 105 residents in the facility (residents were identified by the census list provided by the Administrator on 08/05/24), when staff failed to:</p> <ol style="list-style-type: none"> 1) Post Staffing Information that included the following: <ol style="list-style-type: none"> a. Facility name. b. The current date. c. 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: <ol style="list-style-type: none"> i. Registered nurses. ii. Licensed practical nurses. iii. Certified nurse aides. iv. Resident census. 2) Retain 18 months of staff posting records. <p>These deficient practices could cause residents anxiety not knowing what staff are working. The findings are:</p> <p>A. On 08/08/24 3:45 PM, during an interview with Administrator, he stated the facility does not post resident census numbers or staffing numbers. The administrator stated the units will write which staff are working per shift on a whiteboard inside each unit.</p> <p>B. On 08/09/24 at 9:22 AM, during an observation of Unit C, a whiteboard on the wall indicated the names of staff working on the unit during the shift.</p> <p>C. On 08/09/24 at 9:25 AM, during an observation of Unit D, a whiteboard on the wall indicated the names of staff working on the unit during the shift.</p> <p>D. On 08/09/24 at 9:28 AM, during an observation of Unit E, a small whiteboard on the wall indicated the names of staff working on the unit during the shift.</p> <p>E. On 08/09/24 at 10:43 AM, during an interview with the Director of Nursing, when asked where the staff posting is located, she stated that she posts the staffing schedule outside of her office. She stated the posting only shows staff names and what their schedule will be for the month. She stated they do not post public notice of census numbers along with staffing numbers for each shift (and could not show that the facility held 18 months of posted staffing because they were not posting it).</p>		

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<p>F 0756</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures.</p> <p>41755</p> <p>Based on record reviews and interviews, the facility failed to ensure the consultant pharmacist's recommendations were reviewed and implemented by the physician or that the physician provided a rationale for not following the consultant pharmacist's recommendation for 2 (R #31 and R #50) of 5 (R #31, R #44, R #50, R #51, and R #82) residents reviewed for unnecessary medications. This deficient practice could likely result in residents receiving medications that are no longer necessary and may cause unnecessary drug interactions (changes to medication action caused by being combined with other foods, beverages, or drugs) or adverse side effects (unwanted, undesirable effects from medication). The findings are:</p> <p>R #31</p> <p>A. Record review of the pharmacy's Note To Attending Physician/Prescriber for R #31, dated 06/29/24, revealed:</p> <ol style="list-style-type: none"> 1. R #31 was currently receiving omeprazole (used to treat certain conditions where there is too much acid in the stomach) 20 mg every day. 2. Please evaluate continued need for this medication . 3. The Note To Attending Physician/Prescriber did not include any response from the provider and was not signed by the provider. <p>B. Record review of R #31's physician's orders, dated 03/30/24, revealed an order for Omeprazole 20 mg to be given once daily.</p> <p>C. On 08/08/24 at 2:31 PM, during an interview with the DON, she confirmed the following:</p> <ol style="list-style-type: none"> 1. The pharmacist recommended that the provider evaluate the continued use of Omeprazole for R #31. 2. She was unable to find any documentation that the provider had reviewed the pharmacist's recommendation 3. R #31 had an active physician's order for omeprazole 20 mg. 4. She was unsure of the provider's process for reviewing pharmacy recommendations. <p>R #50</p> <p>D. Record review of the pharmacy's recommendation summary for R #50, dated 05/28/24, revealed:</p> <p>(continued on next page)</p>		

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<p>F 0756</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>1. R #50 is currently receiving ferrous sulfate (iron supplement) 325 mg by mouth twice daily. Laboratory tests performed on 04/30/24, showed that her hemoglobin and hematocrit (H/H laboratory tests related to blood composition and oxygen transport) levels had normalized. Given normalization and in an effort to decrease the potential of adverse effects of taking medication twice daily please consider decreasing to once daily.</p> <p>2. The form was blank and was not signed by the provider.</p> <p>E. Record review of the pharmacy's Note To Attending Physician/Prescriber for R #50, dated 07/31/24, revealed:</p> <p>1. This resident has been taking the antidepressant fluoxetine 40 mg QD (abbreviation for once daily). Please evaluate the current dose and consider dose reduction</p> <p>F. Record review of R # 50's physician's orders revealed the following:</p> <p>1. Order date 01/19/24, fluoxetine 40 mg 1 time a day for depression (mood disorder that causes a persistent feeling of sadness and loss of interest).</p> <p>2. Order date 04/16/24, ferrous sulfate 325 mg give 1 tablet by mouth two times a day for iron deficiency anemia (condition in which blood lacks adequate healthy red blood cells).</p> <p>G. On 08/09/24 at 12:37 PM, during an interview with the DON, she confirmed the following:</p> <p>1. The recommendation to decrease R #50's iron sulfate to once daily was not reviewed by the provider.</p> <p>2. The recommendation to decrease R #50's fluoxetine was not reviewed by the provider.</p> <p>3. The medical record did not contain any documentation from the prescriber regarding either pharmacy recommendation for R #50.</p> <p>4. She was unsure of the provider's process for reviewing pharmacy recommendations.</p> <p>49313</p>		

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<p>F 0758</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>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.</p> <p>49313</p> <p>Based on record review and interview, the facility failed to ensure:</p> <p>1) Residents did not receive psychotropic medications (antidepressants, anti-anxiety medications, stimulants, antipsychotics, and mood stabilizers) unless the medication was necessary to treat a specific psychiatric diagnosis and was documented in the medical record, and</p> <p>2) Have the consent of resident/representative for psychotropic medications</p> <p>for 2 (R #31 and R # 44) of 5 (R #31, R #44, R #50, R #51, and R #82) residents reviewed for unnecessary psychotropic medications. These deficient practices could likely result in residents receiving medications without a medical reason and being at a higher risk of adverse side effects (unwanted, harmful, or abnormal result). The findings are:</p> <p>R #31</p> <p>A. Record review of R #31's medical record, no date, revealed following diagnoses:</p> <p>1. Unspecified psychosis (commonly used if there is inadequate information to make the diagnosis of a specific psychotic disorder) not due to a substance or known physiological condition.</p> <p>2. Dementia (loss of cognitive functioning-thinking, remembering, and reasoning- to such an extent that it interferes with a person's daily life and activities) in other diseases classified elsewhere, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety.</p> <p>3. Post-traumatic stress disorder (PTSD, a disorder that develops in some people who have experienced a shocking, scary, or dangerous event), unspecified.</p> <p>B. Record review of R #31's physician's orders, dated 07/20/22, revealed an order for Sertraline (antidepressant medication used to treat depression) 100 mg, one tablet every morning for depression.</p> <p>C. Record review of R #31's entire medical record, no date, revealed staff did not obtain a consent from R #31's representative for the use of Sertraline.</p> <p>R #44</p> <p>D. Record review of R #44's medical record, no date, revealed R #44 had the following diagnoses:</p> <p>1. Unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety.</p> <p>(continued on next page)</p>		

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<p>F 0758</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>2. Alzheimer's Disease (a progressive disease that destroys memory and other important mental functions), Unspecified.</p> <p>3. Vascular Dementia (problems with reasoning, planning, judgment, memory and other thought processes caused by brain damage from impaired blood flow to the brain), Severe, with psychotic disturbance.</p> <p>E. Record review of R #44's physician's orders, multiple dates, revealed the following orders:</p> <p>1. Order dated 12/22/23, Quetiapine (antipsychotic medication used to treat schizophrenia, acute manic episodes, and major depressive disorder) 50 mg take 1.5 tabs one time a day for aggression.</p> <p>2. Order dated 03/15/24, Quetiapine 100 mg take one tablet at bedtime for aggression.</p> <p>3. Order dated 07/20/22, Divalproex (anticonvulsant medication used to treat seizures, bipolar disorder, and prevent migraine headaches) 125 mg take one capsule twice a day for agitation.</p> <p>4. Order dated 07/15/22, Sertraline 25 mg take one tablet one time a day for agitation.</p> <p>F. Record review of R #44's entire medical record, no date, revealed staff did not obtain a consent from R #44's representative for the use of Sertraline.</p> <p>G. On 08/09/24 at 1:06 PM, during an interview with the DON, she confirmed the following:</p> <p>1. Staff did not obtain written consent for R #31 to take Sertraline.</p> <p>2. Staff did not obtain written consent for R #44 to take Sertraline.</p> <p>3. The expectation is for staff to obtain written consent prior to starting any psychotropic medications.</p> <p>4. Aggression is not a medical diagnosis.</p> <p>5. Agitation is not a medical diagnosis.</p> <p>6. A specific diagnosed condition is needed for the use of psychotropic medication.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Provide and implement an infection prevention and control program.</p> <p>50497</p> <p>Based on record review of the facilities Legionella Water Management Program policy and interview, the facility failed to maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and 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 (105) residents who live in the facility (residents were identified by the Resident Matrix provided by the Administrator on 08/05/24).</p> <p>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:</p> <p>A. Record review of the facilities Legionella Water Management Program Policy revealed the following:</p> <ol style="list-style-type: none"> 1. The facility has a water management program overseen by the water management team. 2. Water management team consists of infection preventionist, the administrator, the medical director (or designee) the director of maintenance and director of environmental services. 3. The purpose of water management program are to identify areas in the water system where Legionella bacteria can grow and spread, and to reduce the risk of Legionnaire's disease. 4. The water management program includes the following elements: <ol style="list-style-type: none"> a. An interdisciplinary water management team b. A detailed description and diagram of the water system in the facility, including the following: <ol style="list-style-type: none"> i. Receiving ii. Cold water distribution iii. Heating iv. Hot water distribution; and v. Waste c. The identification of areas in the water system that could encourage the growth and spread of Legionella or other waterborne bacteria, including the following: <p>(continued on next page)</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 325120	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/09/2024
NAME OF PROVIDER OR SUPPLIER Fort Bayard Medical Center		STREET ADDRESS, CITY, STATE, ZIP CODE 41 Fort Bayard Road 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 (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>i. Storage tanks</p> <p>ii. Water heaters</p> <p>iii. Filters</p> <p>iv. Aerators</p> <p>v. Showerhead and hoses</p> <p>vi. Misters, atomizers, air washers and humidifiers</p> <p>vii. Hot tubs</p> <p>viii. Fountains and</p> <p>ix. Medical devices such as Continuous Positive Airway Pressure (CPAP) machines (ventilation in which a constant level of pressure greater than atmospheric pressure is continuously applied to the upper respiratory tract of a person), hydrotherapy equipment, etc.</p> <p>B. On 08/09/24 at 11:36 AM, during an interview with Infection Control RN #32 he stated the following:</p> <p>1. The water system comes from the local water system.</p> <p>2. Provided a blank copy of the facilities eyewash station checklist.</p> <p>3. The checklists for the water flushes (the process of cleaning the interior of water distribution mains (pipes) by sending a rapid flow of water through the mains.) could not be found and he was not confident they are getting done.</p> <p>4. There were no facility maps or diagrams for the water management system for Legionella that he could provide.</p>		