

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  325131	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  07/22/2024
NAME OF PROVIDER OR SUPPLIER  Spanish Trails Rehabilitation Suites		STREET ADDRESS, CITY, STATE, ZIP CODE  1610 Renaissance Blvd NE Albuquerque, NM 87107	

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 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</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><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41988</b></p> <p>Based on record review and interview, the facility failed to ensure staff revised the care plan for 3 (R #45, #60 and #320) of 2 (R #45, #60 and #320) residents reviewed when staff failed to:</p> <ol style="list-style-type: none"> <li>1. Update the care plan to include Activities of Daily Living (ADL; activities related to personal care such as bathing, showering, dressing, walking, toileting, and eating) care for R #45 and #60.</li> <li>2. Update the care plan to include activity preferences for R #60.</li> <li>3. Inform the Power of Attorney (POA) of changes in care plan to include new behaviors for R #320</li> </ol> <p>These deficient practices are likely to result in residents' care and needs not being addressed if care plans are not updated. The findings are:</p> <p>R #45:</p> <p>A. Record review of R #45's face sheet revealed R #45 was admitted into the facility on [DATE].</p> <p>B. Record review of R #45's Minimum Data Set (MDS; a federally mandated assessment instrument completed by facility staff), dated 05/17/24, revealed R #45 required partial to moderate assistance, in which the helper did less than half the effort. Helper lifted, held, or supported trunk or limbs but provided less than half the effort for most ADL tasks.</p> <p>C. Record review of R #45's care plan, dated 07/10/24, revealed R #45's ADL care requirements were not documented in the care plan.</p> <p>D. On 07/18/24 at 5:44 pm during an interview with the Director of Nursing (DON), she stated staff should have care planned R #45's ADL care requirements, but they did not.</p> <p>R #60:</p> <p>E. Record review of R #60's face sheet revealed R #60 was admitted into the facility on [DATE].</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 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>F. Record review of R #60's MDS, dated [DATE], revealed R #60 required substantial and maximal assistance, in which the helper did more than half the effort. Helper lifted or held trunk or limbs and provided more than half the effort. R #60 was dependent, in which the helper did all the effort. Resident did none of the effort to complete the activity. R #60 required the assistance of two or more helpers for the resident to complete the activity for most ADL tasks.</p> <p>G. Record review of R #60's care plan, dated 07/10/24, revealed R #60's ADL requirements and activity preferences were not care planned.</p> <p>H. On 07/18/24 at 5:19 pm during an interview with the Activities Director (AD), she confirmed R #60's activity preferences were not care planned and should have been.</p> <p>I. On 07/18/24 at 5:45 pm during an interview with the DON, she stated R #60's ADL care requirements should have been care planned and were not.</p> <p>47091</p> <p>R #320:</p> <p>J. Record review of R #320's face sheet revealed R #320 was admitted to facility on 12/27/22 with the following diagnoses:</p> <ul style="list-style-type: none"> <li>- Type 2 diabetes mellitus (a condition that results from the body's inability to process sugar as fuel resulting in high sugar levels).</li> <li>- Muscle wasting and atrophy (the wasting or thinning of muscle mass).</li> <li>- Chronic Kidney Disease (a gradual loss of kidney function that can cause fluid, electrolyte and waste buildup in your body).</li> <li>- A mental health diagnosis was not noted upon admission.</li> </ul> <p>K. Record review of R #320's care plan, dated 09/28/23, revealed the category Behavioral Symptoms was added to the initial care plan on 04/03/24 and included R #320 was having mood and behavior needs, as evidenced by periods of difficulty adjusting to long term care (LTC). The resident refused care at times, such as being changed or use of Purewick [name of] external catheter.</p> <p>L. On 07/18/24 at 4:38 pm during interview with POA, she stated it was discussed, during R #320's care plan conference on 05/24/24, why staff failed to notify the family of any changes in R #320's care plan, to include any new or escalated behaviors. POA stated the facility staff informed her they did not know why the family was not informed.</p> <p>M. On 07/18/24 at 4:54 pm during interview with DON, she stated that according to the initial care plan (09/28/23), staff should have notified R #320's POA of changes made to the care plan, to include any new behavioral symptoms and interventions. The DON stated staff did not notify the family when they made changes to R #320's care plan.</p>		

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<p>F 0686</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41988</b></p> <p>Based on record review and interview, the facility failed to ensure residents received the necessary treatment and services to prevent the development and worsening of pressure wounds (also called a pressure injury; skin damage which results from unrelieved pressure on the body) for 1 (R #128) of 1 (R #128) residents reviewed when staff failed to:</p> <ol style="list-style-type: none"> <li>1. Timely identify the community acquired wound, monitor for changes in the wound, and notify the physician the wound was worsening for R #128.</li> <li>2. Updating wound care treatment orders in relation to R #128's pressure ulcer becoming worse.</li> </ol> <p>This deficient practice likely resulted in R #128's pressure ulcer worsening and developing poor health outcomes. This deficient practice is also likely to lead to residents developing pressure ulcers and wounds worsening. The findings are:</p> <p>A. Record review of R #128's face sheet revealed R #128 was admitted into the facility on [DATE].</p> <p>B. Record review of R #128's admission observation, dated [DATE], revealed staff did not identify pressure ulcers present upon admission.</p> <p>C. Record review of R #128's weekly skin check revealed staff documented the following:</p> <ul style="list-style-type: none"> <li>- Dated [DATE], open areas to bilateral heels and buttock. Wound care as directed. Staff did not stage or measure R #128's wounds on the weekly skin check.</li> <li>- Dated [DATE], open areas to bilateral heels and buttock. Wound care as directed. Staff did not stage or measure R #128's wounds on the weekly skin check.</li> <li>- Dated [DATE], R #128 had a pressure ulcer on her sacrum and both heels with daily wound care. Staff did not stage or measure R #128's wounds on the weekly skin check.</li> <li>- Dated [DATE], R #128 had a pressure ulcer on her sacrum and both heels with daily wound care. Staff did not stage or measure R #128's wounds on the weekly skin check.</li> <li>- Dated [DATE], R #128 had a pressure ulcer on her coccyx with a healing wound on her left foot. Staff did not stage or measure R #128's wounds on the weekly skin check.</li> <li>- Dated [DATE], R #128 had alterations in skin, but staff did not document anything else.</li> <li>- Dated [DATE], R #128 had a pressure ulcer located on her sacrum that measured 0.5 centimeters (cm) length by 0.5 cm width and 3.6 cm depth.</li> <li>- Dated [DATE], R #128 had a pressure ulcer on her sacrum and left heel. Staff did not stage or measure R #128's wounds on the weekly skin check.</li> </ul> <p>(continued on next page)</p>

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<p>F 0686</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>D. Record review of R #128's history and physical (provider assessment), dated [DATE], revealed R #128 had a community acquired pressure ulcer in the sacrum, gluteus, and heels. Staff did not document treatments and measurements.</p> <p>E. Record review of R #128's weekly skin evaluation, dated [DATE], (first weekly skin assessment with pressure ulcer measurements completed by nursing staff) revealed R #128's pressure ulcer was located on her sacrum (a triangular bone in the lower back) and measured 1.5 centimeters (cm) length, 1 cm width, and 0.5 cm depth. Wound was identified as Stage 2 (partial thickness skin loss).</p> <p>F. Record review of R #128's Medication Administration Record (MAR) revealed the following wound care treatments being completed for R #128:</p> <ul style="list-style-type: none"> <li>- On [DATE] through [DATE]: Wound care to sacrum - Clean with wound cleanser, pat dry. Paint with SkinKote (protective prep pad that helps safeguard the skin against irritation) and cover with dry dressing daily.</li> <li>- On [DATE] through [DATE]: Weekly Wound Treatment: Sacrum - Clean with skin integrity, pat dry, apply Therahoney (substance used to treat wounds) to wound bed. Change Monday, Thursday, and as needed if wet/soiled/dislodged.</li> <li>- On [DATE] through [DATE]: Weekly Wound Treatment: Sacrum- Clean with skin integrity, pat dry, apply Therahoney to wound bed, skin prep to peri wound, loosely pack with Maxorb Ag (antimicrobial wound dressing) ribbon, cover with silicone dressing. May change as needed if soiled or dislodged.</li> <li>- On [DATE] through [DATE]: 15 grams (g) liquid protein for pressure ulcer of sacral region.</li> </ul> <p>G. Record review of R #128's care plan dated [DATE] revealed the following:</p> <ul style="list-style-type: none"> <li>- Problem: Resident is at risk for further avoidable/unavoidable skin injuries related to age and aging, dementia, depression, actual pressure injuries present on admission</li> <li>- Approach: Report any signs of skin breakdown (sore, tender, red, or broken areas).</li> </ul> <p>H. Record review of R #128's wound management detail report revealed the following:</p> <ul style="list-style-type: none"> <li>- On [DATE]: wound location- Sacrum, length was 0.5 cm, width is 0.5 cm, depth was 3 cm, and stage 4 (the most serious deep wound that may impact muscle, tendons, ligaments, and bone).</li> <li>- On [DATE]: wound location- Sacrum, length is 0.5 cm, width is 0.5 cm, depth cannot be measured, and stage 4.</li> <li>- On [DATE]: wound location- Sacrum, length was 2.5 cm, width was 2.5 cm, depth was 1 cm, and stage 4.</li> <li>- On [DATE]: wound location- Sacrum, length was 3 cm, width was 3 cm, depth was 2 cm, stage 4, and declining (becoming worse than before). Did not identify signs or symptoms of infection. Comments included the wound was worsening and present upon admission with the provider notified on [DATE] that the wound became a stage 4.</li> </ul> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>I. Record review of R #128's nursing progress notes revealed the following:</p> <ul style="list-style-type: none"> <li>- Dated [DATE] through [DATE], the record did not contain any indication of R #128's pressure ulcer worsening.</li> <li>- Dated [DATE], the ADON #1 and the PA discussed R #128's sacrum pressure ulcer due to R #128's skin appeared to be swollen around the pressure ulcer.</li> </ul> <p>J. Record review of R #128's MAR, dated [DATE], revealed staff completed the following wound care treatments:</p> <ul style="list-style-type: none"> <li>- Dated [DATE] through [DATE]: Weekly Wound Treatment: Sacrum- Clean with skin integrity, pat dry, apply Thera honey to wound bed, skin prep to peri wound, loosely pack with Maxorb Ag (antimicrobial wound dressing) ribbon, cover with silicone dressing. May change as needed if soiled or dislodged.</li> <li>- Dated [DATE] through [DATE]: 15 G liquid protein for pressure ulcer of sacral region.</li> <li>- No additional orders/wound care treatments were ordered or completed.</li> </ul> <p>K. Record review of R #128's PA progress note revealed the following:</p> <ul style="list-style-type: none"> <li>- Dated [DATE], the record did not contain any indication of R #128's pressure ulcer worsening.</li> <li>- Dated [DATE], the record did not contain any indication of R #128's pressure ulcer worsening.</li> <li>- Dated [DATE], the PA was at R #128's bedside to observe R #128's pressure ulcer, and the PA gave orders to send R #128 to the emergency room (ER) for an x-ray due to sacrum pressure ulcer concerns and to rule out osteomyelitis (infection of the bone).</li> </ul> <p>L. Record review of R #128's medical record revealed staff provided wound care daily.</p> <p>M. Record review of R #128's Nurse Practitioner (NP) progress note, dated [DATE], revealed the record did not contain any indication of R #128's pressure ulcer worsening.</p> <p>N. Record review of R #128's hospital documents, dated [DATE], revealed R #128 was diagnosed with sacrococcygeal decubitus ulcer (pressure ulcer located on sacrum) and osteomyelitis. The emergency room (ER) physicians also determined R #128's pressure ulcer was incurable, and R #128 was placed on hospice care.</p> <p>O. On [DATE] at 5:39 pm during an interview with R #128's daughter, she stated R #128's became worse while in the facility which required R #128 to be sent to the hospital in May (2024). R #128's daughter also stated the hospital physician's informed her that R #128's infection was too severe and insisted R #128 be placed on hospice until she died .</p> <p>(continued on next page)</p>

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<p>F 0686</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>P. On [DATE] at 1:03 pm during an interview with Licensed Practical Nurse (LPN) #1, she stated nurses were to notify the Assistant Director of Nursing (ADON) #1 or the Physician Assistant (PA) #1 immediately if resident wounds become worse. LPN #1 also stated the facility completed wound care for R #128, but it quickly became infected. LPN #1 did not know exact date when R #128's wound became infected. LPN #1 stated R #128 preferred to stay in bed and did not want to be repositioned or move from the bed to wheelchair.</p> <p>Q. On [DATE] at 2:31 pm during an interview with PA #1, she stated R #128's wound began to have discharge, so she ordered an x-ray. She stated the x-ray was unable to rule out osteomyelitis. PA #1 also stated R #128's wound worsened, but staff did not make her aware that R #128's worsened until the day she saw R #128 on [DATE]. PA #1 stated she did not see R #128's pressure ulcer until [DATE]. PA #1 stated she should have been notified as soon as R #128's wound was determined to be declining, because she only saw residents once a month or with any new issues.</p> <p>R. On [DATE] at 5:43 pm during an interview with the Director of Nursing (DON), she stated PA #1 should have been notified when R #128's pressure ulcer started to worsen (get bigger in size).</p> <p>S. On [DATE] at 4:28 pm during an interview with ADON #1, she stated she wanted to change R #128's wound care treatment, because the wound began to decline. She stated to do that, they needed to send R #128 to the ER to rule out osteomyelitis. ADON #1 stated R #128 was seen by a provider multiple times, but ADON #1 could not recall informing PA #1 of R #128's pressure ulcer declining. ADON #1 stated she could not provide documentation to show staff informed PA #1 of R #128's pressure ulcer decline prior to [DATE].</p> <p>T. On [DATE] at 3:47 pm during an interview with PA #1, she stated she was aware R #128 did not move her body often. She stated R #128 would not help her move, because R #128 was very weak when she visited the resident. PA #1 stated she was aware of R #128's wound, but she would not have observed the wound unless the nursing staff informed her of a change. PA #1 confirmed R #128's wound was unstageable and then became a stage 4. She stated R #128's documentation that listed R #128's pressure ulcer as a Stage 2 pressure ulcer was incorrect. PA #1 also stated staff eventually told her that R #128's pressure ulcer was worsening. The PA stated she did not know when staff told her, and she did not document that information in R #128's electronic health record.</p>		