

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 325132	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/02/2024
NAME OF PROVIDER OR SUPPLIER Las Cruces Wellness & Rehabilitation LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 175 N Roadrunner Parkway Las Cruces, NM 88011	

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 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41755</p> <p>Based on record review and interview, the facility failed to notify the provider of missed medication doses for 1 (R #59) of 2 (R #59 and R #96) residents reviewed for urinary tract infection (UTI), when they failed to notify the provider that R #59 missed 10 doses of cefuroxime (prescription medication that treats bacterial infections throughout the body) antibiotic. This deficient practice could likely result in residents not receiving necessary care or worsening of medical condition due to lack of treatment. The findings are:</p> <p>A. Record review of R #59's face sheet revealed she was admitted to the facility on [DATE].</p> <p>B. Record review of R #59's hospital follow-up instructions (orders to facility after hospitalization) dated 06/19/24 revealed:</p> <ol style="list-style-type: none"> 1. Diagnosis; urinary tract infection (UTI). 2. New medications, start taking: cefuroxime 500 mg twice daily for 10 days for UTI. <p>C. Record review of R #59's Physician's Orders revealed: Order date 06/19/24, cefuroxime oral tablet give 500 mg by mouth two times a day for UTI for 10 days.</p> <p>D. Record review of R #59's medication administration record (MAR) dated June 2024 revealed R #59 did not receive her cefuroxime on the following dates:</p> <ol style="list-style-type: none"> 1. 06/20/24 at 8:00 AM 2. 06/21/24 at 8:00 PM 3. 06/22/24 at 8:00 AM and 8:00 PM 4. 06/23/24 at 8:00 AM and 8:00 PM 5. 06/24/24 at 8:00 AM and 8:00 PM 6. 06/25/24 at 8:00 AM and 8:00 PM <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 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>E. Record review of R #59's Nurse Progress Notes revealed the record did not contain any documentation that the provider had been notified regarding the resident missed doses of the prescribed antibiotic.</p> <p>F. On 06/28/24 at 3:54 PM, during an interview, the DON confirmed R #59's missed 10 doses of the prescribed antibiotic because the facility did not receive it from the pharmacy, and was unable to confirm that the provider was notified.</p>		

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<p>F 0584</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Many</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>50497</p> <p>Based on observation and interview, the facility failed to provide a homelike environment for all 46 residents. Residents were identified by the resident matrix provided by the Administrator on 06/25/24, when they failed to replace the light bulbs in the dining room. If residents do not have a homelike environment, they could likely become depressed and anxious and feel not valued. The findings are:</p> <p>A. On 06/25/24 at 11:15 AM, an observation of the dining room revealed the following:</p> <ol style="list-style-type: none"> 1. The first ceiling circular hanging light had three (3) light bulbs burnt out and one flickering. 2. The second ceiling circular light had four (4) light bulbs burnt out. 3. The circular hanging light of the bistro close to the hallway had one light bulb burnt out. 4. The circular hanging middle light had one light bulb burnt out. <p>B. On 06/27/24 at 1:42 PM, during an interview with the Administrator revealed the following:</p> <ol style="list-style-type: none"> 1. She confirmed the light bulbs in the dining room were out/off. 2. She stated there is an order for them to be replaced in the next couple of days (no date provided).

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49313</p> <p>Based on record review and interview the facility failed to report the results of the investigation within 5 days of the incident to the State Agency for 2 (R #270 and R #271) of 2 (R #270 and R #271) residents sampled for abuse. If the facility fails to report the results of the investigations to the State Agency within five days, then corrective action may not be taken and residents could likely suffer serious bodily injury. The findings are:</p> <p>R #270</p> <p>A. Record review of the facility's 5-day report (no date) revealed the following:</p> <ol style="list-style-type: none"> 1. R #270 fell on [DATE], that resulted in an emergency room (ER) visit with a diagnosis of acute displacement of the left hip, that required surgery on 03/05/24. 2. The record did not contain any documentation that the follow up report was submitted to the state agency. <p>R #271</p> <p>B. Record review of the facility's 5-day report (no date) revealed the following:</p> <ol style="list-style-type: none"> 1. R #271 sustained a fall on 03/05/24, that resulted in an ER visit and R #271 did not have a serious injury. 2. The record did not contain any documentation that the follow-up report was submitted to the state agency. <p>C. On 07/01/24 at 9:53 AM, during an interview with the Administrator, she confirmed the following:</p> <ol style="list-style-type: none"> 1. She does not know when the 5-day follow-up reports for R #270 and R #271 were sent to the state agency. 2. She was not able to provide proof of when the 5-day follow-up reports for R #270 and R #271 were sent to the State Agency. <p>D. Record review of the State Agency Reporting system, revealed the system did not have any record that the 5-day reports for R #270 or R #271 were received by the State Agency.</p>		

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<p>F 0623</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights.</p> <p>47510</p> <p>49313</p> <p>Based on record review and interview, the facility failed to notify the resident and resident's representative(s) of the transfer in writing for 4 (R #15, R #109, R #266, and R #269) of 4 (R #15, R #109, R #266, and R #269) residents sampled for hospitalization s when they failed to:</p> <ol style="list-style-type: none"> 1. Notify the resident's representative(s) of the transfer to the hospital in writing and in a language and manner they understand for R #15, R #109, R #266, and R #269. 2. Include the name, phone number, and address (mailing and email) of the Office of the State Long-Term Care Ombudsman on the transfer notification form. 3. Send a written copy of the Transfer Notices for R #15, R #266, and R #269 to the Ombudsman. <p>These deficient practices could likely result in the resident and/or their representative not knowing the reason for a transfer, and their rights to advocate and make informed decision regarding their healthcare. The findings are:</p> <p>R #15</p> <p>A. Record review of R #15's medical record revealed R #15 was transferred to the hospital on 06/21/24.</p> <p>B. Record review of R #15's transfer notice revealed the following:</p> <ol style="list-style-type: none"> 1. Staff did not document that a copy of the transfer notice was provided to the resident representative. 2. Staff did not document the name, phone number, or address (mailing and email) of the Office of the State Long-Term Care Ombudsman. 3. Staff did not document that a written copy of the Transfer Notice was sent to the Office of the State Long-Term Care Ombudsman. <p>R #109</p> <p>C. Record review of R #109's medical record revealed R #109 was transferred to the hospital on 04/14/24.</p> <p>D. Record review of R #109's transfer notice revealed staff did not document that a transfer notice was completed and provided to the resident or the resident representative.</p> <p>(continued on next page)</p>		

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<p>F 0623</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>E. On 07/02/24 at 10:34 AM, during an interview, the Administrator confirmed that there was not a transfer notice documented for R #109 on 04/14/24. The administrator said that her expectation is that every time a resident is sent out of the facility for an unanticipated reason, a transfer notice should be done.</p> <p>R #266</p> <p>F. Record review of R #266's medical record revealed R #266 was transferred to the hospital on 06/24/24.</p> <p>G. Record review of R #266's transfer notice revealed the following:</p> <ol style="list-style-type: none"> 1. Staff did not document that a copy of the transfer notice was provided to the resident representative. 2. Staff did not document the name, phone number, or address (mailing and email) of the Office of the State Long-Term Care Ombudsman. 3. Staff did not document that a written copy of the Transfer Notice was sent to the Office of the State Long-Term Care Ombudsman. <p>R #269</p> <p>H. Record review of R #269's medical record revealed R #269 was transferred to the hospital on 06/17/24.</p> <p>I. Record review of R #269's transfer notice revealed the following:</p> <ol style="list-style-type: none"> 1. Staff did not document that a copy of the transfer notice was provided to the resident representative. 2. Staff documented the name and phone number of the Volunteer Ombudsman. 3. Staff did not document the name, phone number, or address (mailing and email) of the Office of the State Long-Term Care Ombudsman. 4. Staff did not document that a written copy of the Transfer Notice was sent to the Office of the State Long-Term Care Ombudsman. <p>J. On 06/27/24 at 4:52 PM, during an interview with the State Long-Term Care Ombudsman, she confirmed the following:</p> <ol style="list-style-type: none"> 1. Staff email her a list of the residents that were transferred. 2. Staff should be including her name and contact information on the transfer notification forms. <p>K. On 07/01/24 at 9:44 AM, during an interview with the Social Worker, she confirmed the following:</p> <p>(continued on next page)</p>		

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<p>F 0623</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>1. She emails the Ombudsman a weekly list of the residents who transferred or discharged from the facility.</p> <p>2. If a resident is sent to the hospital, the nurses are expected to call the family at the time of the resident's transfer to notify them of the resident's condition and need to be transferred to the hospital.</p> <p>3. She does not provide a copy of the transfer notices to the resident's family.</p> <p>L. On 07/01/24 at 9:55 AM, during an interview with LPN #21, she revealed the following:</p> <p>1. When a resident is transferred to the hospital the nurse must notify the resident's family by phone that the resident is being transferred to the hospital.</p> <p>2. The nurse must complete a transfer notification in the electronic medical record and provide a copy of the form to the resident or their representative if they are with the resident at the time of the transfer.</p> <p>3. The nurse must include the name and phone number of the ombudsman on the transfer notification form.</p> <p>4. The nurses have a binder at the nurse's station that includes the name and phone number for the Ombudsman.</p> <p>5. The nurses do not mail a copy of the transfer notification form to the resident's family.</p> <p>M. Record review of the binder at the nurse's station, revealed the following:</p> <p>1. The name and phone number listed as the Ombudsman, was the name and phone number for the Volunteer Ombudsman.</p> <p>2. The binder did not include the name, phone number, or address of the Office of the State Long-Term Care Ombudsman.</p>		

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<p>F 0625</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave.</p> <p>47510</p> <p>Based on record review and interview, the facility failed to ensure that residents and their representatives received a written notice of the bed hold policy which indicated the duration the bed would be held for 4 (R #15, R #109, R #266, and R #269) of 4 (R #15, R #109, R #266, and R #269) residents reviewed for hospitalization . This deficient practice could likely result in the resident and/or their representative being unaware of the bed hold policy upon return from the hospital. The findings are:</p> <p>R #15</p> <p>A. Record review of R #15's medical record revealed R #15 was transferred to the hospital on 06/21/24.</p> <p>B. Record review of R #15's bed hold notice revealed the following:</p> <ol style="list-style-type: none"> 1. Staff did not document how many days a bed would be held for the resident. 2. Staff did not document who was notified about the bed hold notice. 3. Staff did not document that the Bed Hold Notification was provided to the resident. 4. Staff did not document that the Bed Hold Notification form was provided to the resident's family. <p>R #109</p> <p>C. Record review of R #109's medical record revealed the following:</p> <ol style="list-style-type: none"> 1. R #109 was transferred to the hospital on 04/14/24 for respiratory failure (a condition in which your blood doesn't have enough oxygen or has too much carbon dioxide). 2. R #109's medical record did not contain a written notice of bed hold policy for the transfer on 04/14/24. <p>R #266</p> <p>D. Record review of R #266's medical record revealed R #266 was transferred to the hospital on 06/24/24.</p> <p>E. Record review of R #266's bed hold notice revealed the following:</p> <ol style="list-style-type: none"> 1. Staff did not document how many days a bed would be held for the resident. 2. Staff did not document who was notified about the bed hold notice. <p>(continued on next page)</p>		

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<p>F 0625</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>3. Staff did not document that the Bed Hold Notification was provided to the resident.</p> <p>4. Staff did not document that the Bed Hold Notification form was provided to the resident's family.</p> <p>R #269</p> <p>F. Record review of R #269's medical record revealed R #269 was transferred to the hospital on 06/17/24.</p> <p>G. Record review of R #269's bed hold notice revealed the following:</p> <ol style="list-style-type: none"> 1. Staff did not document how many days a bed would be held for the resident. 2. Staff did not document who was notified about the bed hold notice. 3. Staff did not document that the Bed Hold Notification was provided to the resident. 4. Staff did not document that the Bed Hold Notification form was provided to the resident's family. <p>H. On 07/01/24 09:55 AM, during an interview with LPN #21, she revealed the following:</p> <ol style="list-style-type: none"> 1. When a resident is transferred to the hospital, the nurses creates the bed hold notice document in the resident's medical record, but do not document on it, the Business Office is supposed to fill out the the bed hold notice form. 2. The nurses do not notify the resident or family about the bed hold notification. 3. The business office handles the bed hold notification form. <p>I. On 07/01/24 at 10:10 AM, during an interview with the Business Office Manager, she revealed that the business office does not do anything with the Bed Hold Notification Forms.</p> <p>J. On 07/02/24 at 10:34 AM, during an interview, the Administrator confirmed that there was not a bed hold documented for R #109 on 04/14/24. The administrator said that her expectation is that every time a resident is sent out of the facility for an unanticipated reason, a bed hold should be signed by the resident or resident representative as soon as practicable.</p> <p>49313</p>

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<p>F 0636</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49313</p> <p>Based on record review and interview, the facility failed to ensure a comprehensive Minimum Data Set (MDS; a federally mandated assessment instrument completed by facility staff) was completed within 14 calendar days after admission for 1 (R #266) of 4 (R #15, R #108, R #265, and R #266) residents reviewed. This deficient practice could likely result in residents' preferences and care needs not being met. The findings are:</p> <p>A. Record review of R #266's Admission record revealed an admitted [DATE].</p> <p>B. Record review of R #266's Admission MDS assessment revealed the Admission MDS assessment was completed on 07/01/24.</p> <p>C. On 07/02/24 at 9:23 AM, during an interview with the MDS Nurse, she confirmed the following:</p> <ol style="list-style-type: none"> 1. R #266 was admitted to the facility on [DATE]. 2. R #266's Admission MDS assessment was not completed within 14 days of admission. 3. The expectation is for Admission MDS Assessments to be completed within 14 days of admission.

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<p>F 0655</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</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 review and interview, the facility failed to create a baseline care plan (healthcare information necessary to properly care for a resident immediately upon their admission to the facility) within 48 hours, that accurately reflected the resident's current condition for 4 (R #59, R #96, R #110, and R #163) of 5 (R #59, R #96, R #110, R #163 and R #266) residents sampled for baseline care plan when staff failed to:</p> <ol style="list-style-type: none"> 1. Include physician's orders for R #59's antibiotic and use of oxygen. 2. Complete all sections of the baseline care plan and did not include physician's orders for R #96's antibiotic. 3. Complete all sections of the baseline care plan and did not include R #163's dementia (term used to describe a group of symptoms affecting memory, thinking and social abilities)-mild (stage of dementia where cognitive impairment starts to become more noticeable to the patient, as well as friends and family members) diagnosis and physician's orders for R #163 taking an antipsychotic medication (medication that works by changing the effects of chemicals in the brain often used manage the symptoms of mental health conditions). 4. Include physician's orders for R #110's Plaquenil and Lispro medication. <p>These deficient practices could likely result in residents not receiving the appropriate care and services and may place residents at risk of an adverse event (an event, preventable or nonpreventable, that caused harm to a patient as a result of medical care or lack of medical care) or worsening of current condition after admission. The findings are:</p> <p>R #59</p> <p>A. Record review of R #59's face sheet revealed R #59 was admitted to the facility on [DATE].</p> <p>B. Record review of R #59's hospital discharge instructions dated 06/19/24 revealed:</p> <ol style="list-style-type: none"> 1. Diagnosis; urinary tract infection (UTI). 2. New medications, start taking: Cefuroxime (prescription medication that treats bacterial infections throughout the body) 500 mg twice daily for 10 days for urinary tract infection. <p>C. Record review of R #59's Physician's Orders revealed: Order date 06/19/24 oxygen at three (3) liters per minute per nasal cannula (tubing that delivers oxygen into the nose) via O2 (oxygen) concentrator and/or tank continuous (used at all times).</p> <p>D. Record review of R #59's medical record revealed NM (New Mexico) Person Centered Baseline Care Plan dated 06/20/24 did not have a plan in place for R #59's UTI and for the continuous use of oxygen.</p> <p>(continued on next page)</p>		

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<p>F 0655</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>E. On 06/28/24 at 3:54 PM, during an interview, the DON confirmed that R #59's baseline care plan was not customized and did not include R #59's use of continuous oxygen and R #59 received antibiotics for a UTI.</p> <p>R #96</p> <p>F. Record review of R #96's face sheet revealed:</p> <ol style="list-style-type: none"> 1. R #96 was admitted to the facility on [DATE]. 2. Diagnosis of a urinary tract infection (UTI). <p>G. Record review of R #96's Physician's Orders revealed: Order date 05/24/24 cefdinir oral capsule (antibiotic taken orally that is used to treat many different types of infections caused by bacteria) 300 mg, give 1 capsule by mouth two times a day for UTI for seven (7) days.</p> <p>H. Record review of R #96's medical record revealed NM Person Centered Baseline Care Plan dated 05/28/24 was not completed within 48 hours and did not have a plan in place for R #96's UTI.</p> <p>I. On 06/28/24 at 3:37 PM, during an interview, the DON confirmed that R #96's baseline care plan did not have all sections completed within 48 hours of admission and did not include R #96's physician's order for antibiotic treatment for a UTI.</p> <p>R #110</p> <p>J. Record review of R #110's orders revealed the following:</p> <ol style="list-style-type: none"> 1. R #110 was admitted to the facility on [DATE]. 2. An order dated 05/03/24 for Plaquenil (used in the treatment of arthritis) oral tablet two (2) times a day for Rheumatoid arthritis (a chronic inflammatory disorder). 3. An order dated 05/03/24 for Insulin Lispro [NAME] KwikPen Subcutaneous Solution Pen-injector 100 UNIT/ML (to control high blood sugar in people with diabetes). <p>K. Record review of R #110's Baseline Care Plan dated 05/04/24 revealed that R #110's Plaquenil and Lispro were not documented.</p> <p>L. On 07/01/24 at 2:20 PM, during an interview, Social Services said that R #110's Plaquenil and Lispro were not documented in the care plan.</p> <p>R #163</p> <p>M. Record review of R #163's face sheet revealed:</p> <ol style="list-style-type: none"> 1. R #163 was admitted to the facility on [DATE]. 2. Diagnoses: <p>(continued on next page)</p>

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<p>F 0655</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>a. Dementia with anxiety (feeling of worry, nervousness, or unease, typically about something with an uncertain outcome).</p> <p>b. Major depressive disorder (MDD, mood disorder that causes a persistent feeling of sadness and loss of interest).</p> <p>N. Record review of R #163's Physician's Orders revealed: Order date 06/24/24 risperidone oral tablet (antipsychotic medicine taken orally, that works by changing the effects of chemicals in the brain often used to treat schizophrenia and bipolar disorder) 0.5 mg, give 1 tablet by mouth two times a day for MDD and dementia.</p> <p>O. Record review of R #163's medical record revealed NM Person Centered Baseline Care Plan dated 06/27/24 was not completed within 48 hours and did not have a plan in place for dementia diagnosis and use of antipsychotic medication.</p> <p>P. On 06/28/24 at 3:43 PM, during an interview, the DON confirmed that R #163's baseline care plan did not have all sections completed within 48 hours of admission and did not include the diagnosis of dementia and the physician's order for R #163 taking an antipsychotic medication.</p> <p>47510</p>

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47510</p> <p>49313</p> <p>Based on record review, observation, and interview, the facility failed to ensure care plans were complete for 3 (R #106, R #108, and R #265) of 3 (R #106, R #108 and R #265) residents reviewed for care plans. This deficient practice could likely result in staff being unaware of the needs of the residents. The findings are:</p> <p>R #106</p> <p>A. Record review of R #106's medical record revealed R #106 was admitted on [DATE].</p> <p>B. Record review of R #10's care plan dated 06/11/24, revealed the care plan did not address R #10's discharge plan and any referrals to the local contact agency.</p> <p>C. On 07/01/24 at 2:20 PM, during an interview, Social Services confirmed that if it is not documented on R #10's care plan for discharge she did not do it.</p> <p>R #108</p> <p>D. Record review of R #108's medical record revealed R #108 was admitted on [DATE].</p> <p>E. On 06/25/24 at 10:56 AM, during an interview with R #108, he revealed the following:</p> <ol style="list-style-type: none"> 1. He had a urinary tract infection (UTI, an infection in any part of the urinary system) and was receiving antibiotics (medication used to fight bacterial infections) through his Midline catheter (an 8-12 cm long soft, thin tube that is placed into a large vein in the upper arm, with the tip located just below the axilla (armpit).) 2. He completed his antibiotic treatment on 06/23/24. 3. He was unsure if the midline catheter was going to be removed. <p>F. Record review of R #108's physician's orders, dated 06/12/24, revealed an order to change dressing weekly and orders to flush (inject saline into) peripherally inserted central catheter (PICC line, thin tube that's inserted through a vein in your arm and passed through to the larger veins near the heart)/Midline/Central line every shift.</p> <p>G. Record review of R #108's care plan, dated 06/23/24, revealed the following:</p> <ol style="list-style-type: none"> 1. Staff did not document that R #108 had a Midline catheter on the Care plan. 2. Staff did not document instructions for how to care for R #108's midline. <p>(continued on next page)</p>

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>H. On 06/27/24 at 10:47 AM, during an interview with the Minimum Data Set (MDS) Nurse, she confirmed the following:</p> <ol style="list-style-type: none"> 1. R #108 had a midline in his right arm. 2. R #108's care plan indicated that R #108 had an intravenous catheter (IV, short small tube that is placed into a vein). 3. R #108's care plan did not indicate that R #108 had a midline catheter. 4. R #108's care plan did not indicate how staff should care for R #108's midline catheter. 5. Care plan's should be resident specific and indicate specific information for providing care for each resident. <p>R #265</p> <p>I. Record review of R #265's medical record revealed R #265 was admitted on [DATE].</p> <p>J. On 06/25/24 at 10:25 AM, an interview and observation of R #265, revealed the following:</p> <ol style="list-style-type: none"> 1. R #265 stated that he received antibiotics through a catheter in his arm. 2. R #265 stated that he was unsure why he was taking antibiotics. 3. R #265 had redness to both of his lower legs. 4. R #265 stated that the redness on his legs was due to him having problems with swelling and infections in his lower legs. <p>K. Record review of R #265's medical record revealed he had the following diagnoses:</p> <ol style="list-style-type: none"> 1. Primary diagnosis was cellulitis (a deep infection of the skin caused by bacteria) of the left lower limb (lower leg). 2. Cellulitis of the right lower limb. 3. UTI. <p>L. Record review of R #265's physician's orders, dated 06/16/24, revealed an order for Ertapenem (antibiotic used to treat certain infections including pneumonia, urinary tract, and skin) IV every night for 10 days for UTI, and an order to change dressing weekly and to flush PICC/Midline/Central line every shift.</p> <p>M. Record review of R #265's physician's orders, dated 06/17/24, revealed an order to cleanse two open wounds on right lower leg, three times weekly and as needed.</p> <p>N. Record review of R #265's care plan, dated 06/25/24, revealed the following:</p> <p>(continued on next page)</p>

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<ol style="list-style-type: none"> 1. Staff did not document interventions that were in place to care for R #265's diagnosis of cellulitis. 2. Staff did not document R #265's two wounds to the right leg. 3. Staff did not document that R #265 had a peripherally inserted central catheter (PICC line, thin tube that's inserted through a vein in your arm and passed through to the larger veins near the heart). 4. Staff did not document instructions for caring for R #265's PICC line. <p>O. On 06/27/24 at 10:28 AM, during an interview with the MDS Nurse, she confirmed the following:</p> <ol style="list-style-type: none"> 1. R #265 had a PICC line. 2. R #265 care plan indicated that R #265 had an IV. 3. R #265's care plan did not indicate that R #265 had a PICC line. 4. R #265's care plan did not indicate how staff should care for R #265's PICC line. 5. R #265's care plan did not include information for caring for R #265's diagnosis of cellulitis other than providing ordered medications for pain. 6. R #265's care plan should have included what staff should be observing for regarding R #265's cellulitis and any interventions that were being implemented to improve or prevent worsening of R #265's cellulitis in both of his legs. 7. R #265's care plan did not include R #265's two wounds to his right leg.

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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>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>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47510</p> <p>49313</p> <p>Based on record review, and interview, the facility failed to ensure care plan revision and care plan meeting requirements occurred for 5 (R #1, R #2, R #5, R #74, and R #266) of 5 (R #1, R #2, R #5, R #74, and R #266) when the staff failed to:</p> <ol style="list-style-type: none"> 1. Revise the care plan with the most current resident information for R #2, R #5, R #74, and R #266. 2. Have the required Interdisciplinary Team (IDT, team members from different disciplines working collaboratively, with a common purpose, to set goals, make decisions and share resources and responsibilities, and includes other appropriate staff or professionals in disciplines as determined by the resident's needs) members participate in the care plan meeting for R #1 and R #2. <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 #1</p> <p>A. Record review of R #1's admission record revealed R #1 was admitted on [DATE].</p> <p>B. On 06/26/24 at 9:34 AM, during an interview, R #1 said that she wasn't sure if she had participated in her care plan meeting.</p> <p>C. Record review of R #1's medical record revealed the record did not contain any documentation of a care plan meeting.</p> <p>D. On 07/02/24 at 12:01 PM, during an interview, Social Services (SS) said that she has never had a care plan meeting with R #1. SS said she knows what R #1 likes and what her needs are.</p> <p>R #2</p> <p>E. Record review of the admission record, R #2 was admitted to the facility on [DATE].</p> <p>F. On 06/25/24 at 2:36 PM, during an interview with R #2's Family Member (FM) revealed the following:</p> <ol style="list-style-type: none"> 1. FM stated she never attended any meetings in the facility since R #2 was discharged from the hospital. <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 - Some</p>	<p>2. FM did not know she could attend meetings for the residents care plan meetings and was not invited.</p> <p>G. On 06/27/24 at 10:23 AM, during an interview with SS revealed the following:</p> <ol style="list-style-type: none"> 1. Confirmed R #2 admission to the facility was on 04/26/24. 2. She was provided information by the FM for R #2 on 05/01/24 and 05/10/24 through phone call for the care plan. 3. Care plan was not completed with the the IDT members since the facility is short-term. <p>H. Record review of the care plan dated 04/26/24 revealed R #2 FM was not invited to the meeting.</p> <p>R #5</p> <p>I. On 06/25/24 at 10:15 AM, during an interview with R #5, she stated she receives dialysis three times a week and the facility transports her and has fluid restriction (diet which limits the amount of daily fluid consumption each day).</p> <p>J. Record review of the dialysis communication forms dated 05/27/24 and 06/17/24 revealed the following:</p> <ol style="list-style-type: none"> 1. R #5 needs to be in fluid restriction 1 liter per day. 2. R #5 needs to be limited on fluid intake to 0.8 Liter (L) (the basic unit of liquid volume or capacity in the metric system equal to 1.06 quart or 2.12 pints) to 1 Liter (L). <p>K. Record review of R #5 medical orders revealed the following:</p> <ol style="list-style-type: none"> 1. R #5 receives Hemodialysis (HD) (process of filtering the blood of a person whose kidneys are not working normally) Monday, Wednesday, and Friday at 9:00 AM at local clinic. 2. R #5 was on fluid restriction of 1L on the following days Tuesday, Thursday, Saturday, Sunday as ordered on 06/01/24 by physician. <p>L. Record review of R #5 activities of daily living (ADL) sheet for the month of June 2024 revealed R #5 was over on her fluid intake thirteen times during the month.</p> <p>M. Record review of R #5 care plan dated 05/23/24, revealed fluid intake restriction was not documented.</p> <p>N. On 06/26/24 at 2:21 PM, during an interview, with CNA #31 revealed the following:</p> <ol style="list-style-type: none"> 1. The RN's had not told her about R #5 fluid restrictions and R #5 eats and drinks everything. 2. R #5 is on dialysis and attends Monday, Wednesday and Friday. <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 - Some</p>	<p>3. CNA's don't have access to the care plan and only follow RN's orders.</p> <p>4. CNA #34 stated if the resident had a fluid restriction order she would only provide the necessary Cubic Centimeters (CC) (unit used to quantify the flow rate of liquid) of water during the day.</p> <p>O. On 06/27/24 at 8:50 AM, during an interview with RN #32 revealed:</p> <ol style="list-style-type: none"> 1. There was a dialysis communication form dated 06/17/24 for R #5 which indicated R #5 needs to be on a 0.8L to 1L fluid restriction. 2. Hemodialysis was documented but fluid restriction was not documented on the care plan. <p>P. On 06/27/24 at 2:00 PM, during an interview with the DON revealed the following:</p> <ol style="list-style-type: none"> 1. The order of the fluid restriction should be care planned for. 2. Confirmed fluid restriction was not care planned for R #5 since it began in the middle of her stay and stated we probably forgot to document it. <p>R #74</p> <p>Q. Record review of R #74 of admission record revealed: R #74 was admitted to the facility on [DATE].</p> <p>R. Record review of the physician's orders dated 04/29/24 revealed the following:</p> <ol style="list-style-type: none"> 1. Gravity flush percutaneous endoscopic gastrostomy tube (PEG) (endoscopic medical procedure in which a tube (PEG tube) is passed into a patient's stomach through the abdominal wall, most commonly to provide a means of feeding when oral intake is not adequate), with 30mL (Milliliters) (unit is used to measure fluid volume of liquid) every shift. 2. Enteral tube site care: cleanse with soap and water, pat dry and observe skin health. Notify the provider of any changes. 3. Apply split sponge dressing as needed for drainage every shift. 4. Change enteral irrigation syringe, graduated cylinder (narrow laboratory container made of glass or plastic used to measure the volume of liquid) daily. Initial and date. <p>S. Record review of R #74 care plan revealed the following:</p> <ol style="list-style-type: none"> 1. R #74 care plan did not indicate frequencies or times PEG tube is supposed to be cleaned. 2. R #74 care plan did not specify what type of care was ordered for the cleaning of the PEG tube except local care as ordered. <p>T. On 06/25/24 at 1:46 PM, during an interview with LPN #33 she stated the following:</p> <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 - Some</p>	<p>1. R #74 arrived at the facility with a PEG tube.</p> <p>2. R #74 was no longer being fed through PEG tube and eats a regular diet since admitted .</p> <p>3. R #74 PEG-tube gets it flushed out daily.</p> <p>U. On 06/27/24 at 1:52 PM, during an interview with the DON she stated the following:</p> <p>1. R #74 arrived at the facility with a PEG tube.</p> <p>2. R #74 eats a regular diet.</p> <p>3. Provided care of the PEG-tube flushing was completed by wound care nurse. Confirmed there was an order for the PEG tube's care and cleaning from the time of admission to time she was transferred to hospital on 06/25/24. Care plan did not specify what type of care was ordered for the PEG tube.</p> <p>R #266</p> <p>V. Record review of R #266's Admission record revealed R #266 was admitted to the facility on [DATE].</p> <p>W. Record review of R #266's nursing progress note, dated 06/24/24, revealed R #266 was sent to the hospital after being found with white cream on her teeth and tongue.</p> <p>X. On 06/28/24 at 10:34 AM, during an interview with CNA #21, he revealed the following:</p> <p>1. R #266 had ingested creams that were in her bedside table.</p> <p>2. After that incident, R #266's creams are to be kept out of her reach in the bathroom.</p> <p>Y. Record review of R #266's care plan, dated 06/17/24, revealed the following:</p> <p>1. R #266 has behavior problems.</p> <p>2. R #266 had removed her midline three times and unplugged her call light and placed a spoon in the outlet.</p> <p>3. R #266's care plan was not revised to include information that she had ingested cream on 06/24/24 or any interventions that the facility initiated to prevent R #266 from ingesting cream again.</p> <p>Z. On 06/28/24 at 10:19 AM, during an interview with the DON, she confirmed the following:</p> <p>1. R #266's has impulsivity and poor safety awareness.</p> <p>2. R #266's care plan was not updated to include that she had ingested cream on 06/24/24.</p> <p>3. R #266's care plan should have been updated to include keeping creams in the bathroom, out of R #266's reach</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>49313</p> <p>Based on interview and record review, the facility failed to keep residents free from accidents for 1 (R #266) of 1 (R #266) resident reviewed, when they failed to ensure that skin creams were stored out of resident's reach. These deficient practices could likely result in residents obtaining medical equipment which can cause injury/death. The findings are:</p> <p>A. On 06/25/24 at 1:39 PM, during an interview with R #266's family member, she stated that R #266 had gone to the hospital on 06/24/24.</p> <p>B. Record review of R #266's nursing progress note, dated 06/24/24, revealed R #266 was sent to the hospital after being found with white cream on her teeth and tongue.</p> <p>C. On 07/02/24 at 9:55 AM, during an interview with RN #21, the following was revealed:</p> <ol style="list-style-type: none"> 1. On 06/24/24, R #266 was in her room and had white cream all over her mouth, tongue, and teeth. 2. There were two tubes of barrier cream (a topical formulation used to place a barrier between the skin and contaminants that may irritate the skin, typically used for incontinence care) and a jar of white zinc cream (used to treat and prevent diaper rash) in R #266's bed side drawer. 3. The jar of zinc cream was empty. 4. R #266 was sent to the hospital and returned shortly after. 5. After R #266 ingested the cream, all of her creams were removed from her bedside table. <p>D. Record review of R #266's care plan, dated 06/17/24, revealed the following:</p> <ol style="list-style-type: none"> 1. R #266 has behavior problems. 2. R #266's had removed her midline catheter (an 8-12 cm long soft, thin tube that is placed into a large vein in the upper arm, with the tip located just below the axilla (armpit) three times. 3. R #266 had unplugged her call light and placed a spoon in the outlet. <p>E. On 06/28/24 at 10:19 AM, during an interview with the DON, she confirmed the following:</p> <ol style="list-style-type: none"> 1. R #266's has impulsivity (tendency to act without thinking) and poor safety awareness. 2. When residents have poor safety awareness they should be assessed for potential for danger. 3. R #266 was not assessed for potential for danger. <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>4. They should have identified that there was a potential for R #266 to ingest the creams since she had removed her midline 3 times and removed her call plug and put a plastic spoon in the call plug outlet.</p>		

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NAME OF PROVIDER OR SUPPLIER Las Cruces Wellness & Rehabilitation LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 175 N Roadrunner Parkway Las Cruces, NM 88011	

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41755</p> <p>Based on interview and record review, the facility failed to ensure that a resident who enters the facility with diagnosis of urinary tract infection (UTI) received appropriate treatment for 1 (R #59) of 2 (R #59 and R #96) residents reviewed for UTI when they failed to ensure that a resident received all doses of antibiotic as prescribed to treat the UTI. This deficient practice could result in residents being susceptible to worsening of infection or becoming septic (potentially life-threatening when the body responds to infection by damaging its own tissues) The findings are:</p> <p>A. On 06/25/24 at 10:31 AM, during an interview, R #59 laid in bed and reported she was discharged to the facility about a week ago due to being in the hospital for a urinary infection.</p> <p>B. Record review of R #59's face sheet revealed R #59 was admitted to the facility on [DATE].</p> <p>C. Record review of R #59's hospital discharge instructions dated 06/19/24 revealed:</p> <ol style="list-style-type: none"> 1. Diagnosis; urinary tract infection (UTI). 2. New medications, start taking: cefuroxime (prescription medication that treats bacterial infections throughout the body) 500 mg twice daily for 10 days for urinary tract infection. <p>D. Record review of R #59's Physician's Orders revealed: Order date 06/19/24, cefuroxime oral tablet give 500 mg by mouth two times a day for UTI for 10 days.</p> <p>E. Record review of R #59's medication administration record (MAR) dated June 2024 revealed she did not receive her cefuroxime on the following dates:</p> <ol style="list-style-type: none"> 1. 06/20/24 at 8:00 AM 2. 06/21/24 at 8:00 PM 3. 06/22/24 at 8:00 AM and 8:00 PM 4. 06/23/24 at 8:00 AM and 8:00 PM 5. 06/24/24 at 8:00 AM and 8:00 PM 6. 06/25/24 at 8:00 AM and 8:00 PM <p>F. Record review of R #59's progress notes revealed the following:</p> <ol style="list-style-type: none"> 1. 06/20/24 at 8:37 AM cefuroxime on order 2. 06/21/24 at 11:35 PM cefuroxime on order <p>(continued on next page)</p>

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>3. 06/22/24 at 8:52 AM cefuroxime on order has not been delivered, none in e kit (emergency kit where medication that has not been delivered from pharmacy can be obtained.)</p> <p>4. 06/22/24 at 10:07 PM cefuroxime not in cart (medication cart that holds residents' medications) or pyxis (machine where medication can be obtained prior to delivery from pharmacy)</p> <p>5. 06/23/24 at 9:33 AM cefuroxime on order from pharmacy</p> <p>6. 06/23/24 at 8:16 PM cefuroxime awaiting arrival from pharmacy</p> <p>7. 06/24/24 at 9:32 AM cefuroxime on order from pharmacy</p> <p>8. 06/24/24 at 11:14 PM cefuroxime awaiting arrival from pharmacy</p> <p>9. 06/25/24 at 09:01 PM cefuroxime not available</p> <p>G. On 06/28/24 at 3:54 PM, during an interview, the DON confirmed that R #59 missed 10 doses out of 13 doses of the antibiotic medication ordered to treat her UTI because the facility did not receive the medication from the pharmacy.</p>

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<p>F 0711</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure the resident's doctor reviews the resident's care, writes, signs and dates progress notes and orders, at each required visit.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49313</p> <p>Based on record review and interview, the facility failed to ensure residents have a written, signed, and dated progress note from the provider (physician or nurse practitioner) at the time of each visit for 1 (R #15) of 1 (R #15) residents reviewed for physician's visits This deficient practice could likely result in the resident's needs not being met due to facility staff being unaware of resident's status related to lack of written, signed, and dated progress notes at the time of the visit.</p> <p>A. Record review of R #15's Electronic Medical Record (EMR) revealed R #15 was admitted to the facility on [DATE].</p> <p>B. Record review of R #15's physician's progress notes revealed the following:</p> <ol style="list-style-type: none"> 1. History and Physical (H&P), dated 04/14/24, revealed the H&P note was a late entry entered on 06/20/24. 2. Provider progress note, dated 04/15/24, revealed the note was a late entry entered on 06/20/24. 3. Provider progress notes dated 04/16/24, revealed the note was a late entry entered on 06/20/24. 4. Provider progress notes dated 04/17/24, revealed the note was a late entry entered on 06/20/24. 5. Provider progress notes dated 04/18/24, revealed the note was a late entry entered on 06/20/24. 6. Provider progress notes dated 05/01/24, revealed the note was a late entry entered on 06/20/24. 7. Provider progress notes dated 05/02/24, revealed the note was a late entry entered on 06/20/24. 8. Provider progress notes dated 05/03/24, revealed the note was a late entry entered on 06/20/24. 9. Provider progress notes dated 06/01/24, revealed the note was a late entry entered on 06/20/24. 10. Provider progress notes dated 06/02/24, revealed the note was a late entry entered on 06/20/24. 11. Provider progress notes dated 06/03/24, revealed the note was a late entry entered on 06/20/24. <p>C. On 07/01/24 at 1:36 PM, during an interview with Nurse Practitioner #21, he revealed the following:</p> <ol style="list-style-type: none"> 1. He sees residents at the facility almost daily. 2. He is behind on entering progress notes into the medical records. <p>(continued on next page)</p>		

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<p>F 0711</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>3. He entered several late entries for R #15 on 06/20/24.</p> <p>4. He waits to get a collection of notes on residents before he enters them.</p> <p>D. On 07/01/24 at 2:35 PM, during an interview with the Administrator, she confirmed that her expectation is for the providers to enter their notes timely (she did not specify what timely meant).</p>

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<p>F 0712</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure that the resident and his/her doctor meet face-to-face at all required visits.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49313</p> <p>Based on record review and interview, the facility failed to ensure that residents had a physician visit at least every 30 days for the first 90 days after admission for 1 (R #15) of 1 (R #15) residents reviewed for physician's visits. This deficient practice could likely result in residents not receiving the required medical assessment which could cause a delay in care and treatment of medical conditions. The findings are:</p> <p>A. Record review of R #15's Electronic Medical Record (EMR) revealed R #15 was admitted to the facility on [DATE].</p> <p>B. Record review of R #15's entire EMR revealed the medical record did not contain any documentation that R #15 was seen by the physician.</p> <p>C. On 07/01/24 at 2:35 PM, during an interview with the Administrator, she confirmed the following:</p> <ol style="list-style-type: none"> 1. There was no documentation in R #15's medical record from the physician. 2. She was unable to determine if R #15 was seen by a physician. 3. She was unsure how frequently R #15's physician sees residents in the facility. 4. Her expectation is for physicians to see their residents at least once every 30 days for the first 90 days.

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p>50497</p> <p>Based on observation, record review, and interview, the facility failed to store medications properly for all 17 residents in rooms 135-151 (residents were identified by the Resident Matrix provided by the Administrator on 06/25/24), when they failed to ensure the medication cart did not contain loose medications. This deficient practice could likely result in residents obtaining or being administered medication not prescribed to them, receiving medications that are less effective and may result in adverse side effects. The findings are:</p> <p>A. On 06/29/24 at 2:55 PM, during an observation of the medication cart assigned to room's 135-151, one white oval tablet was loose between the medication cards (cardboard and foil packaging prefilled with prescription medication) in the second drawer of the medication cart.</p> <p>B. On 06/29/24 at 2:57 PM, during an interview with LPN #34, he confirmed there was a loose white tablet stating, I will remove it.</p> <p>C. Record review of the facility's Storage of Medication Policy dated September 2018, revealed Medications and biologicals are stored properly, following manufacturer's or provider pharmacy recommendations, to maintain their integrity and to support safe effective drug administration. The medication supply shall be accessible only to licensed nursing personnel, pharmacy personnel, or staff members lawfully authorized to administer medications. Medication storage should be kept clean, well lit, organized and free of clutter.</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p>47510</p> <p>Based on record review and interview, the facility failed to ensure medical records were complete and accurate for 1 (R #18) of 5 (R #1, R #18, R #109, R #110 and R #111) residents reviewed for documentation accuracy. This deficient practice has the potential to negatively impact the care staff provide to meet residents' needs due to missing or inaccurate records and resident information. The findings are:</p> <p>A. Record review of R #18's medical record dated 05/30/24 revealed R #18 has a diagnosis of Dysphagia (difficulty or discomfort in swallowing).</p> <p>B. Record review of R #18's care plan dated 06/02/24 revealed R #18's mouth needed to be checked after meals for pocketed (when food is held in the mouth for an extended amount of time without swallowing) food and debris.</p> <p>C. On 06/26/24 at 2:23 PM, during an interview, LPN #11 said that the nurses are the ones that will check to see if R #18 has pocketed food after meals. LPN #11 said that she does not document when she checks R #18 for pocketing after meals. LPN #11 said she doesn't know how to tell if R #18 is being checked after meals.</p> <p>D. On 06/27/24 at 10:17 AM, during an interview, the DON confirmed staff do not document when R #18 was checked for food pocketing after meals. The DON said her expectation is that staff should be documenting that they are checking R #18 after meals.</p>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>50497</p> <p>Based on observation, interview, and record review the facility failed to follow proper infection control practices for 1 (R #74) of 2 (R #5 and R #74) residents identified during random observation when the facility failed to ensure resident's nasal cannulas (a device that delivers extra oxygen through a tube and into your nose) were labeled with the date that they were changed. This deficient practice could likely result in the spread of contagious and resistant illnesses to other residents. The findings are:</p> <p>A. On 06/25/24 at 1:31 PM, during an observation of R #74's room, the nasal cannula tubing was not dated to indicate when it was changed.</p> <p>B. Record review of R #74's physician's orders dated 06/05/24 revealed the following:</p> <ol style="list-style-type: none"> 1. Oxygen titration 0-6L (liters) via nasal cannula to keep saturations > (greater than) 92% every shift for hypoxia. 2. Oxygen at 4 Liters Per Minute (LPM) via nasal cannula every shift. <p>C. On 06/25/24 at 1:33 PM, during an interview with LPN #34 she confirmed the following:</p> <ol style="list-style-type: none"> 1. Nasal cannula oxygen tubing did not have a date. 2. She stated tubing gets changed on Sundays. 3. We get so busy; we forget to check if the tubing was dated. 		