

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 32E027	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/25/2024
NAME OF PROVIDER OR SUPPLIER Miners Colfax Medical Center		STREET ADDRESS, CITY, STATE, ZIP CODE 900 South 6th Street Raton, NM 87740	

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 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</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** 41988</p> <p>Based on observation, record review, and interview, the facility failed to develop and implement a comprehensive person-centered care plan for 1 (R #7) of 2 (R #7 and #12) residents reviewed for comprehensive care plans when staff did not develop a care plan for oxygen (O2) use. Failure to develop and implement a resident-centered care plan may result in staff not understanding and implementing the needs and treatments of residents, possibly resulting in decline in abilities. The findings are:</p> <p>A. Record review of R #7's face sheet revealed R #7 was admitted into the facility on [DATE].</p> <p>B. Record review of R #7's physician orders, dated 10/22/23, revealed an order for O2 at 2 liters per minute (lpm) via nasal cannula (tubing that provides O2 through the nose). Keep O2 saturations at 90 percent (%), as needed (PRN).</p> <p>C. Record review of R #7's care plan, dated 04/24/24, revealed the record did not contain documentation regarding R #7's O2 use.</p> <p>D. On 04/23/24 at 9:50 am during an observation, R #7 did not wear O2, but R #7's O2 tubing was connected to the O2 wall mount in her room.</p> <p>E. On 04/24/24 at 11:38 am during an interview with Certified Nursing Assistant (CNA) #1, she stated R #7 used O2 as needed.</p> <p>F. On 04/24/24 at 5:17 pm during an interview with the Assistant Director of Nursing (ADON), she confirmed R #7 had orders for as needed O2 use. She stated staff did not care plan R #7's oxygen use, but they should have.</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 - 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>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41988</p> <p>Based on observation, record review, and interview, the facility failed to ensure staff revised the care plan for 1 (R #6) of 1 (R #6) residents reviewed when staff failed to update the care plan to reflect new dietary behaviors. 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>A. Record review of R #6's face sheet revealed R #6 was admitted into the facility on [DATE].</p> <p>B. On 04/24/24 at 11:53 am during an interview with Registered Nurse (RN) #1, she stated R #6 would chew his food and spit it in the trash.</p> <p>C. On 04/24/24 at 5:02 pm during a dinner observation, R #6 ate dinner in the dining room with a trash can next to him. R #6 threw food in the trash.</p> <p>D. On 04/24/24 at 5:05 pm during an interview with Certified Nursing Assistant (CNA) #1, she confirmed R #6 threw food in the trash for awhile, and he also did that if he ate in his room. CNA #1 stated everyone knew R #6 threw food in the trash at each meal.</p> <p>E. Record review of R #6's care plan, dated 04/24/24, revealed the following:</p> <ul style="list-style-type: none"> - Focus: When the resident ate and drank they coughed and had phlegm. - Interventions/Tasks: The resident's diet was changed to mechanical soft texture per Speech-language pathologist (SLP) recommendations. - Staff did not document food or meal behaviors in R #6's care plan. <p>F. On 04/24/24 at 5:41 pm during an interview with the Assistant Director of Nursing (ADON), she stated staff should have updated R #6's care plan to include his meal behavior. The ADON confirmed R #6's meal behavior was not care planned.</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure services provided by the nursing facility meet professional standards of quality.</p> <p>47031</p> <p>Based on observation, record review, and interview, the facility failed to meet professional standards of care for 1 (R #4) of 1 (R #4) residents by not obtaining physician's orders for the use of a therapeutic cup. This deficient practice is likely to result in residents receiving assistive devices that are not needed or ordered by the physician. The findings are:</p> <p>A. On 04/24/24 at 5:02 pm during observation of the dinner meal in the dining room, R #4 drank coffee out of a sippy cup (a drinking cup designed to prevent or reduce spills).</p> <p>B. Record review of R #4's physicians orders revealed the record did not contain an order for the use of a sippy cup.</p> <p>C. Record review of R#4's care plan revealed the care plan did not address the use off a sippy cup.</p> <p>D. On 04/24/24 at 5:50 pm, during a interview with CNA #1, she confirmed R#4 drank out of a sippy cup at all meals.</p> <p>E. On 04/24/24 at 5:50 pm, during a interview with Nurse #2, she stated R #4 drank from a sippy cup, but he did not have an order for it. She stated there should be an order for the use of a sippy cup.</p> <p>F. On 04/25/24 at 10:00 am during an interview with the Director of Nursing, she confirmed R #4 did not have an order for the sippy cup, but he should.</p>

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<p>F 0698</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide safe, appropriate dialysis care/services for a resident who requires such services.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41988</p> <p>Based on interview and record review, the facility failed to ensure staff communicated and collaborated with the dialysis (clinical purification of blood as substitute for normal kidney functioning) facility regarding dialysis care and services for 2 (R #6 and #12) of 2 (R #6 and #12) residents reviewed for dialysis. If the facility is unaware of the status, condition, or complications that arise during dialysis treatment then residents are likely not to receive the appropriate monitoring and care they need. The findings are:</p> <p>R #6:</p> <p>A. Record review of R #6's face sheet revealed R #6 was admitted into the facility on [DATE].</p> <p>B. Record review of R #6's physician orders, dated 06/29/22, revealed an order to increase dialysis chair time/treatment duration to 3 hours and 15 minutes starting on 07/01/22.</p> <p>C. Record review of R #6's care plan, dated 04/24/24, revealed the following:</p> <p>- Focus: The resident was very weak after dialysis treatments, and it took away most of the resident's energy for the day.</p> <p>- Interventions/Tasks: The resident needed someone to propel their wheelchair down to dialysis on dialysis days, Monday, Wednesday, and Friday.</p> <p>D. Record review of R #6's dialysis communication record (communication form used to communicate between the facility and the dialysis center about the patients status), dated 03/01/24 through 03/31/24, revealed eleven of the thirteen forms did not contain information regarding the resident's post dialysis status, the date, and the signature of the facility nurse.</p> <p>E. Record review of R #6's dialysis communication record, dated 04/01/24 through 04/25/24, revealed eight of the ten forms did not contain information regarding the resident's post dialysis status, the date, and the signature of the facility nurse.</p> <p>F. On 04/24/24 at 11:54 am during an interview with Registered Nurse (RN) #1, she stated she was not aware she needed to complete the post dialysis section of form or document vitals in the electronic health record (EHR) post dialysis.</p> <p>G. On 04/24/24 at 11:58 am during an interview with RN #2, she stated none of the staff completed the post dialysis sections on communication forms. RN #2 stated she did not complete the post dialysis section on residents' dialysis communication forms when the residents returned from dialysis.</p> <p>H. On 04/24/24 at 5:46 pm during an interview the Assistant Director of Nursing (ADON), she stated the expectation was for staff to complete dialysis communication forms. The ADON stated nursing staff should be aware of residents' conditions when residents return from dialysis.</p> <p>R #12:</p> <p>(continued on next page)</p>		

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<p>F 0698</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>I. Record review of R #12's face sheet revealed R #12 was admitted into the facility on [DATE].</p> <p>J. Record review of R #12's physician orders, dated 10/07/21, revealed an order for hemodialysis (a machine that filters wastes, salts, and fluid from the blood when the kidneys cannot do it) every Monday, Wednesday, and Friday.</p> <p>K. Record review of R #12's care plan, dated 04/25/24, revealed the following:</p> <ul style="list-style-type: none"> - Focus: The resident's kidneys did not function properly. Since May of 2019, the resident went to dialysis three times a week. - Interventions/Tasks: The resident needed someone to propel their wheelchair down to dialysis on dialysis days, Monday, Wednesday, and Friday. <p>L. Record review of R #6's dialysis communication record dated 03/01/24 through 03/31/24, revealed ten of the thirteen forms did not contain information regarding the resident's post dialysis status, the date, and the signature of the facility nurse.</p> <p>M. Record review of R #6's dialysis communication record, dated 04/01/24 through 04/25/24, revealed ten of the twelve forms did not contain information regarding the resident's post dialysis status, the date, and the signature of the facility nurse.</p> <p>N. On 04/25/24 at 10:15 am during an interview with the Director of Nursing (DON), she confirmed R #6's and R #12's dialysis communication forms were not completed and should have been.</p>

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p>47031</p> <p>Based on record review and interview, the facility failed to meet professional standards for maintaining resident records for 1 (R # 6) of 1 (R #6) residents when staff failed to ensure R #6's code status readily viewable in the resident's Electronic Health Record (EHR). This deficient practice is likely to result in residents end-of-life medical care choices not being honored. The findings are:</p> <p>A. Record review of R #6's EHR revealed R #6 was admitted to facility on 07/09/09, but the record did not contain the resident's code status on the EHR on the banner. [The facility's practice was to note the resident code status on the top page that opened first when accessing the resident's EHR. This is called the banner].</p> <p>B. On 4/25/24 at 9:47 am, during an interview with Director of Nursing (DON), she stated all residents should have an advanced directives in their chart. The DON confirmed R #6's code status was not on the resident's EHR banner, and it should be on the banner.</p> <p>C. On 4/25/24 at 9:58 am, during an interview with the Social Services (SS), she stated she completed all advanced directives upon admission, and there should be one in all the residents' charts. The SS stated she completed R #6's advanced directive. She confirmed R #6's code status was not on the resident's EHR banner, and it should be on the banner.</p>