STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	32E027	A. Building B. Wing	05/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Miners Colfax Medical Center	900 South 6th Street Raton, NM 87740

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41988 Based on record review and interview, the facility failed to ensure the Minimum Data Set (MDS; a federally mandated comprehensive assessment of a resident's functional, medical, psychosocial and cognitive assessment completed by facility staff) was accurate for 1 (R #13) of 1 (R #13) resident reviewed for anticoagulant (blood thinner) medication use. This deficient practice could result in a failure to provide adequate care and treatment of the resident's needs. The findings are: A. Record review of R #13's face sheet revealed R #13 was admitted into the facility on [DATE]. B. Record review of R #13's physician's orders revealed the following: 1. 01/26/24: Aspirin (analgesic medication used to relieve pain) 81 mg (milligram) oral tablet one time a day. 2. 01/26/24: Clopidogrel (antiplatelet used to prevent platelets or blood cells from clumping together to form a clot) 75 mg one time a day. - R #13 was not prescribed an anticoagulant medication. C. Record review of R #13's latest MDS Section O- Special Treatments, Procedures, and Programs dated 03/06/25 revealed R #13 was administered an anticoagulant medication within the past 14 days. D. On 05/15/25 at 12:09 pm during an interview with the Assistant Director of Nursing/ MDS Coordinator (ADON/MDSC), she stated that she thought R #13 was taking an anticoagulant medication and that's why his MDS was documented that way. The ADON/MDSC confirmed R #13 was not and did not take an anticoagulant medication, making R #13's MDS was inaccurate, and it should not have been.

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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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41988 Based on observation, record review, and interview, the facility failed to ensure staff revised the care plan for 2 (R #'s 1 and 18) of 2 (R #'s 1 and 18) residents reviewed when staff failed to: 1. Update R #1's plan of care to include skin irritation (itchiness) that required topical skin medication/lotion. 2. Update R #18's plan of care to include Albuterol (medication used to prevent and treat wheezing and difficulty breathing) use via a nebulizer (oral medical device used for producing a fine spray of liquid), and storage of nebulizer. These deficient practices are likely to result in residents' care and needs not being addressed if care plans are not updated. The findings are: R #1: A. Record review of R #1's face sheet revealed R #1 was admitted into the facility on [DATE]. B. Record review of R #1's physician orders dated 03/06/25 revealed R #1 was prescribed [NAME] External Lotion 0.5-0.5 % (percent), apply to legs topically as needed for itching. C. Record review of R #1's nursing progress notes revealed the following: 1. 03/06/25 at 11:14 am: R #1 stated that he is itchy at night when he goes to bed. R #1 was educated and encouraged to use the [NAME] External Lotion that is available to him. 2. 05/14/25 at 9:41 am: R #1 complained of itches on his legs and sometimes other parts of his body. D. Record review of R #1's care plan reviewed on 05/15/25, revealed the care plan did not contain any documentation for [NAME] External Lotion use or R #1's chronic itchiness. E. On 05/13/25 at 10:38 am during an interview with R #1, he stated that his arms and legs are always itchy, and the nurses were providing medication for that. F. On 05/14/25 at 5:51 pm during an interview with Certified Nursing Assistant (CNA) #2, she confirmed R #1 had experienced chronic skin irritation and R #1 will require medication to treat the itchiness. G. On 05/15/25 at 12:18 pm during an interview with the Assistant Director of Nursing (ADON), she confirmed R #1's chronic skin irritation and topical medication treatment should be care planned and was not. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R #18: H. Record review of R #18's face sheet revealed R #18 was admitted into the facility on [DATE]. I. Record review of R #18's Medication Administration Record (MAR) dated 04/01/25 through 04/30/25 revealed R #18 was administered Albuterol Sulfate Inhalation Nebulization 2.5 mg per 3 ml (milliliter), every four hours as needed for wheezing shortness of breath, 16 times throughout the timeframe. J. Record review of R #18's MAR dated 05/01/25 through 05/14/25 revealed R #18 still had active orders for Albuterol Sulfate Inhalation Nebulization (medication was only on hold for 05/03/25 through 05/08/25). K. Record review of R #18's care plan reviewed on 05/13/25, revealed R #18's Albuterol use with a nebulizer including nebulizer storage was not care planned. L. On 05/13/25 at 10:30 am during an observation and interview, R #18's nebulizer hung on an oxygen concentrator above his bed, and not in a bag for storage. R #18 confirmed he still uses his nebulizer sometimes when he needs it. M. On 05/14/25 at 3:34 pm during an interview with Registered Nurse (RN) #1, she stated that R #18 requires treatment for wheezing most mornings. RN #1 also stated that R #18's nebulizer should be stored in a bag when not in use. RN #1 confirmed R #18's nebulizer was stored above his bed and not in a bag, and R #18's Albuterol with nebulizer use should be care planned, but was not. N. On 05/15/25 at 12:23 pm during an interview with the ADON, she stated that R #18 does not like to store his Albuterol nebulizer in a storage bag when not in use. The ADON confirmed R #18's Albuterol use with a nebulizer and R #18's preference to not store the nebulizer in a bag when not in use, were not care planned and should have been.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41988 Based on observation, record review, and interview, the facility failed to provide a quality care that meets professional standards for 2 (R #3 and R #41) of 2 (R #3 and R #41) residents when the facility failed to: - Obtain physician orders prior to providing oxygen (O2) and having O2 equipment readily available in a resident's room. - Obtain physician orders for over the counter medicaiton (OTC; medications sold to individuals without a prescription) and for the resident to self-administer medication. If the facility is not obtaining physician orders for medications and treatments, then the physician and staff may be unaware of the potential for medication interactions, overdosing, or side effects. The findings are: R #3 A. Record review of R #3's face sheet revealed R #3 was admitted into the facility on [DATE]. B. Record review of R #3's physician orders reviewed on 05/13/25, revealed no physician order for O2 use. C. Record review of R #3's care plan reviewed on 05/13/25, revealed O2 use was not care planned. D. On 05/13/25 at 2:42 pm during an observation and interview with R #3, O2 tubing with a saline humidifier (device that moistens oxygen delivered through a humidifier) was present above R #3's bed. R #3 stated that he will use the O2 if he needs it. E. On 05/14/25 at 3:54 pm during an interview with Registered Nurse (RN) #1, she stated that R #3 did not use O2. RN #1 confirmed the O2 tubing and humidifier present in R #3's room should not have been there without a physician's order. F. On 05/14/25 at 5:56 pm during an interview with Certified Nursing Assistant (CNA) #3, she stated that R #3 will sometimes wear O2 if he wants to, and the CNAs will always offer O2 to R #3. G. On 05/15/25 at 12:24 pm during an interview with the Assistant Director of Nursing (ADON), she stated that R #3 does not use O2 and the O2 tubing and humidifier that was in R #3's room should not have been in there without physician orders. R #41 H. On 05/12/25 at 3:52 PM, during an observation, the cabinet located R #41's room contained the following: (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Bacitracin zinc ointment (OTC antibiotic), - Bigeloil topical pain gel (OTC pain relief gel), - Lidocaine ointment (OTC anesthetic.) I. Record review of R #41's physician orders, dated May 2025, revealed the following: - The resident did not have orders for bacitracin zinc ointment, Bigeloil topical pain gel, or lidocaine ointment. - The resident did not have an order to self-administer medication. J. Record review of R #41's care plan reviewed on 05/23/25, revealed the care plan did not contain information regarding the resident self-administering OTC medication. K. On 05/12/25 at 4:57 PM, during an interview, the Assistant Director of Nursing (ADON) stated the resident's family brought in R #41's OTC medications. She stated all medications require a physician order, to include OTC medications.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39509 Based on record review and interview, the facility failed to ensure that 5 (R #6, 8, 10, 17, and 22) of 5 5 (R #6, 8, 10, 17, and 22) residents medication regimen was reviewed by a licensed pharmacist. That the licensed pharmacist documented any recommendations or changes to each resident's medication regimen and that the physician reviewed these recommendations and submitted a written response to accept or reject these recommendations. These deficient practices could likely result in residents receiving medications that are no longer necessary and may cause unnecessary drug interactions and adverse side effects. The findings are: R #6 A. Record review of R #6 face sheet dated 05/14/25 revealed he was admitted to the facility on [DATE] with multiple diagnoses. B. Record review of R #6's physician orders revealed multiple medication orders started on various dates. C. Record review of R #6's medical record including his electronic medical record (EMR) and his paper medical record (PMR) from 06/01/24 to 05/15/25 failed to find any written communication between the facility pharmacist and R #6's medical provider that indicated that R #6's medications had been reviewed by the pharmacist, that the pharmacist had submitted any recommendations regarding R #6's medication regimine or that the medical provided had reviewed and responded to any pharmacist recommendations. R #8 D. Record review of R #8 face sheet dated 05/14/25 revealed he was admitted to the facility on [DATE] with multiple diagnoses. E. Record review of R #8's physician orders revealed multiple medication orders started on various dates. F. Record review of R #8's medical record including his electronic medical record (EMR) and his paper medical record (PMR) from 08/01/24 to 05/15/25 failed to find any written communication between the facility pharmacist and R #8's medical provider that indicated that R #8's medications had been reviewed by the pharmacist, that the pharmacist had submitted any recommendations regarding R #8's medication regimine or that the medical provided had reviewed and responded to any pharmacist recommendations. R #10 G. Record review of R #10 face sheet dated 05/14/25 revealed he was admitted to the facility on [DATE] with multiple diagnoses. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	H. Record review of R #10's physician orders revealed multiple medication orders started on various dates. I. Record review of R #10's medical record including his electronic medical record (EMR) and his paper medical record (PMR) from 02/01/25 to 05/15/25 failed to find any written communication between the facility pharmacist and R #10's medical provider that indicated that R #10's medications had been reviewed by the pharmacist, that the pharmacist had submitted any recommendations regarding R #10's medication regimine or that the medical provided had reviewed and responded to any pharmacist recommendations. R #17 J. Record review of R #17 face sheet dated 05/14/25 revealed he was admitted to the facility on [DATE] with multiple diagnoses. K. Record review of R #17's physician orders revealed multiple medication orders started on various dates. L. Record review of R #17's medical record including his electronic medical record (EMR) and his paper medical record (PMR) from 05/01/24 to 05/15/25 failed to find any written communication between the facility pharmacist and R #17's medical provider that indicated that R #17's medications had been reviewed by the pharmacist, that the pharmacist had submitted any recommendations regarding R #17's medication regimine or that the medical provided had reviewed and responded to any pharmacist recommendations. R #22 M. Record review of R #22 face sheet dated 05/14/25 revealed he was admitted to the facility on [DATE] with multiple diagnoses. N. Record review of R #22's physician orders revealed multiple medication orders started on various dates. O. Record review of R #22's medical record including his electronic medical record (EMR) and his paper medical record (PMR) from 09/01/24 to 05/15/25 failed to find any written communication between the facility pharmacist and R #22's medical provider that indicated that R #22's medications had been reviewed by the pharmacist, that the pharmacist had submitted any recommendations regarding R #22's medication regimine or that the medical provided had reviewed and responded to any pharmacist recommendations. P. On 05/14/25 at 11:25 am during interview with Director of Nursing (DON), she stated that the facility conducts a monthly meeting in which the contracted pharmacist and the medical director attends. She stated that during this meeting, resident medications are discussed. She stated there was no documentation of this discussion that was contained in any resident's EMR or PMR. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Q. On 05/14/25 at 11:25 am during interview with the Administrator (ADM), he stated that the facility does not have a formal review of resident medications. He acknowledged that there was no documentation of resident medications being reviewed by the pharmacist, that the pharmacist was not providing written medication recommendations to the medical provider and that there was no pharmacy recommendations for the medical provider to respond to. ADM stated that he was aware that this was a necessary process and that he was working to begin the process in the upcoming month.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 52440 Based on observation, interviews, and record review, the facility failed to ensure medications, including over the counter medications (OTC; medications sold to individuals without a prescription), were not accessible to all residents located on the [NAME] Hall. This deficient practice could result in impairment or decline in a resident's mental or physical condition if a resident came in contact with the medications. The findings are: A. On 05/12/25 at 3:52 PM, during an observation, the cabinet located R #41's room contained the following: - Bacitracin zinc ointment (OTC antibiotic), - Bigeloil topical pain gel (OTC pain relief gel), - Lidocaine ointment (OTC anesthetic.) B. Record review of R #41's physician orders dated May 2025, revealed the following: - The resident did not have orders for bacitracin zinc ointment, Bigeloil topical pain gel, or lidocaine ointment. - The resident did not have an order to self-administer medication. C. On 05/12/25 at 4:51 PM, during an interview, Certified Nurse Aide (CNA) #1 stated staff should label and keep the bacitracin zinc ointment, Bigeloil topical pain gel, and lidocaine ointment in the medication cart. D. On 05/12/25 at 4:57 PM, during an interview, the Assistant Director of Nursing (ADON) stated the resident's family brought in R #41's OTC medications. She stated staff should keep all medications in the medication cart.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 47031 Based on observation and staff interview, the facility failed to store and serve food under sanitary conditions when staff failed to ensure: 1. Proper labeling and dating of food items in the kitchen freezer. 2. Inadequate food storage practices including leaving box of white rice open to air. 3. Employees wore appropriate hair restraints. These deficient practices are likely to affect all 23 residents listed on the census provided by the Administrator on 05/12/25 and may lead to foodborne illnesses in residents if proper food storage and safe food handling practices are not adhered. A. On 5/12/2025 at 2:00 PM, during an observation of the kitchen revealed one twenty-five-pound box of white rice was left open to air and stored on a shelf in the dry storage area. B. On 05/12/2025 at 2:07 PM during an interview, the Dietary Manager (DM) confirmed that the box of rice was left open and stated it should have been sealed for proper storage. C. On 05/13/2025 at 4:43 PM during an observation of the kitchen revealed two five-pound bags of frozen blueberries stored in freezer #1 without labels and dates D. On 05/13/2025 at 4:45 PM during an interview, Dietary [NAME] (DC) #1 confirmed the blueberries were not labeled and dated and acknowledged that the blueberries should have been. E. On 05/15/2025 at 11:35 AM during an observation of the kitchen revealed that Dietary Aide (DA) #1 was not wearing a beard guard. F. On 05/15/2025 at 11:38 AM during an interview, the DM confirmed that DA #1 was not wearing a beard guard and stated that he should have been.