

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  32E032	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  01/30/2025
NAME OF PROVIDER OR SUPPLIER  Colfax General Ltc		STREET ADDRESS, CITY, STATE, ZIP CODE  615 Prospect Avenue Springer, NM 87747	

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 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>41988</p> <p>Based on record review and interview, the facility failed to report the results of an investigation regarding allegations of abuse for 2 (R #'s 8 and 22 ) of 2(R #'s 8 and 22) residents reviewed for incidents.</p> <p>If the facility is not submitting the summary of the facility's investigation to the State Agency (SA), then the State Agency is unable to appropriately triage (review) the allegation for further investigation. The findings are:</p> <p>A. Refer to F0610 for related findings.</p> <p>B. On 01/30/25 at 2:33 pm during an interview with the Administrator (ADM), she stated the incident involving R #8 and R #22 with an agency Certified Nurse Assistant (CNA) was not reported to the SA. The ADM stated that R #8 only reported experiencing issues with the agency CNAs bedside manner towards him and R #22, but the facility could not define what bedside manner meant in this case. When asked if this could be considered verbal abuse, the ADM was unsure and stated she could not rule out verbal abuse with the information that was provided to her. The ADM confirmed all allegations of abuse, including verbal abuse, should be reported to the SA.</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 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41988</b></p> <p>Based on record review and interview, the facility failed to complete a thorough investigation and report the investigation findings within five working days, for an allegation of abuse for 2 (R #'s 8 and 22) of 2 (R #'s 8 and 22) residents reviewed for incidents.</p> <p>If the facility is not completing an accurate and thorough investigation and submitting the summary of the facility's investigation to the State Agency, then the State Agency (SA) is unable to appropriately triage (review) the allegation for further investigation. The findings are:</p> <p>A. Record review of the facility's investigation report dated 12/23/24 revealed the following:</p> <ul style="list-style-type: none"> <li>- R #8 requested to speak to the Administrator (ADM) regarding concerns of bedside manner of an agency Certified Nursing Assistant (CNA) while assisting R #22.</li> <li>-R #8 stated that his back was turned when the agency CNA assisted R #22, he had concerns of poor bedside manner regarding that interaction.</li> <li>- Multiple residents were interviewed on 12/23/24 with the residents confirming poor attitude and bedside manner experienced by the agency CNA.</li> <li>- Due to the residents consistent highlighted concerns regarding the agency CNAs bedside manner, the agency CNAs contract was terminated.</li> </ul> <p>B. Record review of R #8's face sheet revealed R #8 was admitted into the facility on [DATE].</p> <p>C. Record review of R # 8's Minimum Data Set (MDS- Resident Assessment and Care Screening) Section C: Cognitive Patterns- Brief Interview for Mental Status (BIMS: assessment used to monitor cognition; 0 to 7 points equals severely impaired cognition, 8 to 12 points equals moderately impaired cognition, and 13 to 15 points equals intact cognition) dated 11/14/24 revealed R #8 was scored as 15.</p> <p>D. Record review of R #8's nursing progress notes dated 12/20/24 through 01/01/25 revealed the notes did not contain any documentation of any allegations of abuse against an agency CNA (Certified Nursing Assistant) for R #8.</p> <p>E. Record review of R #22's face sheet revealed R #22 was admitted into the facility on [DATE].</p> <p>F. Record review of R #22's MDS Section C: Cognitive Patterns- BIMS dated 11/27/24 revealed R #22 was scored as 11.</p> <p>G. Record review of R #22's nursing progress notes dated 12/20/24 through 01/01/25 revealed no notes were present that indicated any allegations of abuse against an agency CNA for R #22.</p> <p>H. On 01/27/25 at 4:42 pm during an interview with R #22, he stated that he could not remember any incidents involving staff.</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>I. On 01/28/25 12:42 pm during an interview with R #8, he stated that several weeks ago an agency CNA did not talk to him nicely and had poor bedside manner. R #8 also stated that the agency CNA was rough with his roommate (R #22) on two different occasions which resulted in R #22 screaming out in pain. R #8 confirmed that he reported all incidents to the nursing staff and the ADM.</p> <p>J. On 01/29/25 at 4:01 pm during an interview with an anonymous employee (AE), they stated the incident involving R #8 and R #22 occurred sometime around 12/21/24 through 12/22/24. R #8 informed the AE that the agency CNA was rough with R #22, which caused R #22 to be in pain. The AE also stated this incident should have been reported to the SA, but it was not because R #22's arms did not have trauma to the skin.</p> <p>K. On 01/29/25 at 5:32 pm during an interview with Registered Nurse (RN) #1, she stated she heard about this incident (incident involving an agency CNA and R #'s 8 and R #22) as a rumor outside of the facility, but she was not involved with any part of the incident.</p> <p>L. On 01/30/25 at 9:43 am during an interview with CNA #1, she stated R #8 called her to his room after the incident with the agency CNA and reported that the agency CNA was rough with R #22 and rude to R #8. CNA #1 confirmed she informed the previous Assistant Director of Nursing (ADON) right away, and the previous ADON stated she would investigate the incident. The CNA #1 also stated that she did not remember the date when she informed the previous ADON.</p> <p>M. On 01/30/25 at 11:01 am during an interview with RN #2, she stated she was not there for the incident with R #8 and R #22, but the facility reporting process is for nursing staff to notify management so a complete investigation can be conducted.</p> <p>N. On 01/30/25 at 12:27 pm during an interview with RN #3, she stated she reported the incident regarding R #8 and R #22 to the ADM as soon as she was aware of what allegedly happened. RN #3 stated R #8 informed her that when the agency CNA was assisting and turning R #22, R #22 screamed very loudly and in a way R #8 had never heard before (sometime during the dates of 12/21/24 through 12/22/24). RN #3 confirmed R #8 was completely cognitive, so she reported the allegations of abuse involving R #8, R #22, and the agency CNA to the ADM. RN #3 also confirmed that she immediately assessed R #22 for injury (on 12/22/24), but due to R #22's cognitive decline, R #22 denied any concerns and R #22 did not have any injuries present. RN #3 also stated she believed the agency CNA pulled R #22's arm too roughly, which caused pain. RN #3 confirmed that she wrote a statement about R #8 and R #22's abuse allegations involving the agency CNA, and RN #3 delivered the statement to the ADM in the morning on 12/23/24.</p> <p>O. On 01/30/25 during an interview with the ADM, she stated that she talked to R #8 because of the concerns of R #8 had involving the agency CNA and how the agency CNA treated R #8 and R #22. The ADM stated R #8 informed her that the agency CNA was rude to R #8 and R #22, so she had an internal investigation completed. The ADM also stated that abuse was not reported to her after a facility team completed the investigation and staff did not provided her with any information about the agency CNA being rude to R #8 and R #22. The ADM confirmed that if she had been made aware of abuse allegations, then she would have reported the incident to the SA, but she did not.</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>P. On 01/30/25 at 3:05 pm during an interview with the Social Services Director (SSD), she stated she was informed of this incident by the ADM on 12/23/24, so she was a part of the investigation team that reviewed the allegations of poor bedside manner and staff rudeness towards R #8 and R #22. The SSD stated that she interviewed R #8 and R #22 on 12/23/24. The SSD also stated that she was not made aware of staff roughness towards R #22 by the agency CNA during the investigation, so that was not investigated. The SSD confirmed that she was unaware of facility nursing staff having information related to this incident because she only interviewed residents during the investigation for the allegation of abuse involving R #8 and R #22, and facility staff was not interviewed during this investigation. The SSD also confirmed that if she had gotten more information from residents about the agency CNA being rough with R #22, then she would have interviewed facility nursing staff as well.</p> <p>Q. On 01/30/25 at 3:52 pm during an interview with the Interim Director of Nursing (DON) and new DON, they both confirmed that they would expect facility nursing staff to be interviewed during an investigation for allegations of abuse involving residents.</p>		