STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	32E032	A. Building B. Wing	04/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Colfax General Ltc	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)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 52443 Based on record review and interview, the facility failed to notify the resident's provider of a decline in condition for 1 (R #1) of 1(R #1) resident reviewed for changes of condition (new or worsening symptoms). If the facility is not notifying the provider when the resident experiences a change of condition, then the provider is unable to make decisions related to treatment and advocate for the resident's care. The findings are: A. Record review of R #1's face sheet revealed he was admitted to the facility on [DATE] with the following diagnoses: -Acute Kidney Failure (condition in which the kidneys can't filter waste from the blood). -Dementia (memory loss). -Chronic Obstructive Pulmonary Disease unspecified (shortness of breath). -Alcoholic Cirrhosis (damage of cells, swelling, and thickening of the liver). -Cerebral Vascular Accident (Stroke). -UTI (Urinary Tract Infection). B. Record review of R #1's daily care/progress notes revealed the following: - On 03/11/25, R #1 had refused to eat for a couple of days. - On 03/12/25, R #1's Medical Doctor (MD) progress notes stated that if R #1's condition did not improve in 24 hours, Staff will need to consider Emergency Department (ED) evaluation and hydration. The progress note further stated, nurses will contact providers with any concerns or changes. -On 03/16/25, R #1 was sent to the emergency room (ER) for a decline in condition. Due to sepsis (systemic infection) and UTI, R #1 was transported via air medical transport to [NAME], Texas for specialty evaluation and care. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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NAME OF PROVIDER OR SUPPLIER Colfax General Ltc		STREET ADDRESS, CITY, STATE, ZIP CODE 615 Prospect Avenue Springer, NM 87747	

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The record did not contain any progress notes from 03/13/25 through 03/15/25 documenting R #1's health status, evaluations, or a decline in condition. -On 03/16/25 the progress note stated, R #1 presents with altered mental status, R #1 had 5 teeth removed on 02/25/25. The gums at removal sites are yellowish green. C. On 04/22/25 at 2:47 pm during an interview with Registered Nurse (RN) #1, she confirmed that staff should have called or texted the physician concerning any change in condition. D. On 04/22/25 at 3:11 pm during an interview with the Director of Nursing (DON), she confirmed the Medical Doctor (MD) should have been notified. E. On 04/22/25 at 3:56 pm during a phone interview with Provider #1, he stated that he was not notified of R #1's decline in condition. F. On 04/22/25 at 3:57 during a phone interview with Provider #2, she stated she was not notified of R #1's decline in condition.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 52443 Based on observation, record review, and interview, the facility failed to meet professional standards for 3 (R # 5, 6, and 7) of 9 (R #1, 5, 6, 7, 8, 9, 10, 11, and 12) residents when staff failed to: 1. Ensure R #5's, R #6's, and R #7's humidity (attachable bottle to moisten administered oxygen) is added to concentrator and that O2 concentrator is capable of having humidy added. 2. Label and date oxygen (O2) tubing per physician orders for R #5, R #6 and R #7. If the facility is not following physician orders, then residents are at risk of adverse outcomes and inadequate monitoring of treatment. The findings are: R #5: A. Record review of R #5's face sheet revealed R #5 was admitted into the facility on [DATE]. B. Record review of R #5's physician orders dated 02/28/25, revealed an order to change humidifiers (device used to moisten medical O2) and nasal cannulas (device used to administer medical O2) on the night shift every Friday. C. On 04/22/25 at 2:06 pm during an observation of R #5's room, R #5's concentrator (oxygen machine) did not have a humidifier as ordered by Physician and the O2 tubing was not labeled or dated . R #6: D. Record review of R #6's face sheet revealed R #6 was admitted into the facility on [DATE]. E. Record review of R #6's physician orders dated 02/28/25, revealed change humidifier/cannulas, date and initial every night shift every Fri (Friday). F. On 04/22/25 at 2:08 pm during an observation of R #6's room, R #6's concentrator did not have a humidifier as ordered. Label and dates were missing from the equipment. R #7: G. Record review of R #7's face sheet revealed R #7 was admitted into the facility on [DATE]. H. Record review of R #7's physician orders dated 02/28/25, revealed an order to change humidifiers and nasal cannulas on the night shift every Friday. I. On 04/22/25 at 2:10 pm during an observation of R #7's room, R #7's concentrator was found to be without a humidifier. Label and dates were missing from equipment. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	J. On 4/22/25 at 2:20 pm during an interview with Certified Nursing Assistant (CNA) #2, she stated the humidifier bottle and tubing should be changed weekly. CNA #2 confirmed staff are supposed to label and date the tubing and bottle. CNA #1 stated she is unaware of how humidity can be added to the affected resident concentrators. K. On 4/22/25 at 2:47 pm during an interview with Registered Nurse (RN) #1, she stated the CNAs and nurses are responsible for changing O2 tubing and the humidifiers as ordered by Physician. RN #1 confirmed the nasal cannulas and humidifier should be labeled and dated. RN #1 stated she doesn't know how to change or add humidity to the affected resident concentrators. RN #1 stated, I would expect these concentrators are to be replaced and be able to administer humidified air. L. On 4/22/25 at 3:11 pm during an interview with the Director of Nursing (DON), she stated, all the residents with concentrators should have a concentrator that is capable of adding humidity. The DON confirmed the affected resident concentrator was not capable of adding humidity.

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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. 52443 Based on observation and interview, the facility failed to store and serve food under sanitary conditions when staff failed to ensure: 1. Food items were labeled and dated in the kitchen refrigerator and freezer. 2. Food was stored appropriately and not left open to air in the kitchen freezer. These deficient practices are likely to affect all 32 residents listed on the resident census list provided by the Administrator on 04/21/25 and are likely lead to foodborne illnesses in residents if food is not being stored properly and safe food handling practices are not adhered to. The findings are: A. On 04/21/25 at 1:03 pm, observation of the kitchen revealed the following: - 3 pecan pies, 3 apple pies, 1 sheet cake, and 1 box of salmon fish fillets were not labeled or dated and stored in the kitchen freezer. - 1 package of pepperoni, 1 pack of chicken nuggets, and 1 box of salmon fish fillets were open to air and stored in the kitchen freezer. - 1 box of eggs was sealed but was not labeled or dated in the kitchen refrigerator. - 2, 12 pack soda cases were stored on the floor in the dry storage, and one case had been opened. B. On 04/21/25 at 1:34 pm during an interview with the Dietary Manager (DM), he confirmed all items listed on finding A and stated that all food items should be labeled, dated, stored appropriately.

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. 52443 Based on observation and interviews, the facility failed to ensure there was a functioning call light system that allowed residents to call for assistance for 1 (R #13) of 5 (R #2, #3, #4, #5, and #13) residents observed for call lights. If the facility does not have a functioning communication system, then residents are unlikely to get their immediate needs met by facility staff. The findings are: A. On 04/22/25 at 9:17 am during a call light observation, R #13's call light was activated, but it did not sound at the nurse's station or the unit to alert staff of call light activation. The call light did not activate the marquee (electronic signage displaying room numbers) notification, the nurse's station visual alert or nurse's station audible alert. B. On 04/22/25 at 9:20 am during interview with Registered Nurse (RN #1), RN #1 stated call lights should alert staff at the nurses station when activated and should display on marquee in the unit halls. RN #1 confirmed R #13's call light did not alert the nursing station when activated nor display on marquee of the call light and should have. C. On 04/22/25 at 9:25 am during interview with Certified Nursing Assistant (CNA) #1, she confirmed R #13's call light was not functioning. CNA #1 stated R #13's call light should be fully functioning when activated and it was not. D. On 04/22/25 at 9:36 am during a call light observation, R #13's call light was activated two more times and did not alert nurses station or display notification on marquee. E. On 04/22/25 at 9:36 am during an interview with CNA #1, she confirmed R #13's call light was still not functioning properly, and should have been. CNA #1 will notify maintenance. F. On 04/23/25 at 3:11 pm during an interview with Director of Nursing (DON), she stated, she was not notified of a call light issue. DON stated the facility policy is that the CNAs should report the malfunction to the charge nurse, then report the malfunction to maintenance. DON stated, while the call light is not working, staff should be rounding on the affected room every 30 minutes to ensure resident safety. DON confirmed the 30 minute room rounding was not occurring, and R #13's call light should have been fixed already.