

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 0578</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41988</p> <p>Based on record review and interview, the facility failed to ensure the resident's current advance directive (a document which provides an individual's wishes for emergency and life saving care) was available in the resident's Electronic Health Record (EHR) and/or available in physical form for the facility staff for 1 (R #34) of 1 (R #34) residents reviewed for advance directives.</p> <p>This deficient practice is likely to cause confusion and delay potentially life saving procedures. The findings are:</p> <p>A. Record review of R #34's physician orders dated [DATE] revealed R #34 was a Do Not Resuscitate (DNR- a person has decided not to have cardiopulmonary resuscitation (CPR) attempted on them if their heart or breathing stops) for her advanced directive code status.</p> <p>B. Record review of R #34's care plan dated [DATE] revealed R #34 was a DNR for her advanced directive code status.</p> <p>C. Record review of R #34's face sheet revealed R #34 was admitted into the facility on [DATE].</p> <p>D. Record review of R #34's EHR revealed the record did not contain an advanced directive form.</p> <p>E. On [DATE] at 2:04 pm during an interview with the Social Services Director (SSD), she confirmed R #34's advanced directive code status was not uploaded into R #34's EHR nor was it available in physical form for nursing staff and should have been.</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 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41988</p> <p>Based on observation and interview, the facility failed to store and serve food under sanitary conditions when staff failed to ensure:</p> <ol style="list-style-type: none"> 1. Food items were labeled and dated in the kitchen refrigerator and freezer. 2. Kitchen refrigerators were free from dietary staff personal food. 3. Food was stored appropriately and not left open to air in the kitchen. 4. Salad was stored on ice prior to meal service. <p>These deficient practices are likely to affect all 32 residents listed on the resident census list provided by the Administrator on 01/27/25 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.</p> <p>The findings are:</p> <p>A. On 01/27/25 at 12:39 pm, observation of the kitchen revealed the following:</p> <ul style="list-style-type: none"> - One Styrofoam To-Go container labeled [Name of [NAME] 1] dated 01/27/25 was stored in the kitchen refrigerator. - Three large plastic bags of crinkle cut fries were not labeled or dated and stored in freezer #1. - One large plastic bag of frozen meat was not labeled or dated and stored in freezer #1. - Seven large plastic bags of biscuits were dated 11/09 but not labeled and stored in freezer #1. - Two large plastic bags of cubed meat dated 12/01 but not labeled and stored in freezer #2. - Four large bags of chicken tenders dated 12/01 but not labeled and stored in freezer #2. <p>B. On 01/27/25 at 12:53 pm during an interview with the Dietary Manager (DM), he stated that all food should be labeled, dated, and staff should not store their food in the resident refrigerator.</p> <p>C. On 01/30/25 at 11:45 am, observation of the kitchen revealed one box of 20 count [NAME] Spunkmeyer muffins were left open to air and stored on a kitchen table near freezer #2.</p> <p>D. On 01/30/25 at 11:47 am during an interview with the DM, he confirmed the muffins were left open to air and stated they should have been sealed for storage.</p> <p>E. On 01/30/25 at 12:04 pm, observation of the dining room revealed the following:</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>- One plastic container of salad mix and one plastic container of chopped tomatoes were stored on the hot steam table, the salad mix and the tomatoes were not on ice while the DM served the residents their lunch plates. The salad was served to all residents in dining room.</p> <p>F. On 01/30/25 at 12:05 pm during an interview with the DM, he confirmed the salad mix and tomatoes were not cold and stated they should have been stored on ice during meal service.</p>		

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<p>F 0814</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Dispose of garbage and refuse properly.</p> <p>41988</p> <p>Based on observation and interview, the facility failed to ensure that all garbage and refuse containers have lids or are otherwise covered in the kitchen. This deficient practice could likely affect all 32 residents identified on the resident census list provided by the Administrator on 01/27/25.</p> <p>This deficient practice could likely result in shelter and feeding of pests. The findings are:</p> <p>A. On 01/30/25 at 11:45 am, observation of the kitchen revealed the following:</p> <ul style="list-style-type: none"> - One small trash can filled with trash was not covered and stored under the dishwashing station next to an open box of muffins. - One large trash can was filled with trash and not covered next to the three compartment kitchen sinks and stove. <p>B. On 01/30/25 at 11:48 am during an interview with the Dietary Manager (DM), he confirmed both trash cans were uncovered in the kitchen near food prep areas. The DM stated all trash cans should be stored with lids.</p>