STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	325059	A. BUILDING _____ B. WING _____	07/29/2014

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ESPANOLA VALLEY NURSING AND REHAB	720 HACIENDA STREET ESPANOLA, NM 87532

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 0170 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	**Send and promptly deliver unopened mail to residents.** Based on record review and interview, the facility did not honor the residents' right by not delivering mail on Saturdays to all 79 residents in the facility, listed on the Resident Census provided by the Minimum Data Set (MDS) Coordinator on 07/20/14. This deficient practice results in residents having to wait 2 days before receiving their mail. The findings are: A. Record review of the Social Services Policy Manual dated 2001, revised November 2010 revealed, Mail will be delivered to the residents within twenty-four (24) hours of delivery on premises or to the facility's post office box (including Saturday deliveries). B. On 07/25/14 at 11:10 am during interview with R #43, she stated that residents' mail is not delivered on Saturdays. C. On 07/29/14 at 2:20 pm during interview with R #31, he stated I do not receive mail on Saturdays. D. On 07/25/14 at 5:43 pm during interview with the Activities Director (AD), she confirmed that the activity department is responsible for mail delivery. When asked if there are activity staff on Saturday, she stated, Yes, but we do not have access to the mail. E. On 07/29/14 at 2:28 pm during interview with the Receptionist when asked if mail is delivered on Saturdays, she responded, It might have been in the past but right now, no because front office is closed. When we had a ward clerk it was delivered. It has been maybe since April they let the ward clerk go. And you know how things disappear, they don't give it to staff any more.
F 0225 **Level of harm** - Immediate jeopardy **Residents Affected** - Many	**1) Hire only people with no legal history of abusing, neglecting or mistreating residents; or 2) report and investigate any acts or reports of abuse, neglect or mistreatment of residents.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility failed to conduct employment background checks and criminal conviction checks prior to offering employment for 6 out of 11 employees. These employees were offered employment before a Consolidated Online Registry (COR) screening was completed. Upon review of these employee records on 07/28/14, the COR had still not been obtained. They also continued to employee the Van Driver (VD) for 6 months after receiving information that revealed he had 2 past criminal convictions that made him ineligible for employment. These deficient practices resulted in an Immediate Jeopardy (IJ) being identified at the facility on 07/28/14 at 4:10 pm. The facility took corrective action by providing an acceptable Plan of Removal. Based on the plan, interventions included doing an audit of currently employed direct caregiver employees to determine if the facility has clearance documentation on file, and any direct caregiver who does not have the documentation will not be allowed to work until clearance has been received by the facility. The facility will obtain required clearance on all new hires prior to the beginning of their employment, including the COR, OIG Screening and finger print submission within 20 days. Based on the Plan of Removal and observation, the IJ was lifted on 07/28/14 at 4:50 pm. This resulted in the scope and severity being reduced from a scope and severity of L to Level 2, Scope F. Based on record review and interview, the facility failed to protect residents from abuse, neglect and exploitation for all 79 residents in the facility, listed on the Resident Census provided by the Minimum Data Set (MDS) Coordinator on 07/20/14 by: 1. Not conducting employment background checks and criminal conviction checks prior to offering employment for 6 out of 11 employees reviewed during Abuse Prohibition Review for new employees pre-screening 2. Continuing to employee an individual who had past criminal convictions that made him ineligible for employment for 1 of 11 employees reviewed for Abuse Prohibition Review. If the facility employs individuals with past criminal convictions and is not ensuring that their employees do not have a history of abuse, neglect, exploitation, mistreatment, and misappropriation of property, they put the residents at risk of being victims of abuse, neglect and exploitation. The findings are: Findings for Pre-screening: A. Record review of the employee file for Certified Nurse Aide (CNA) #3, revealed that she was hired by the facility on 02/24/14 and there was no Consolidated Online Registry (COR) screening completed. B. Record review of the employee file for Registered Nurse (RN) #3, revealed that she was hired by the facility on 01/16/14 and there was no Consolidated Online Registry (COR) screening completed. C. Record review of the employee file for CNA #4 revealed that he was hired by the facility on 05/18/12 and there was no Consolidated Online Registry (COR) screening completed. D. Record review of the employee file for CNA #6, revealed that she was hired by the facility on 04/28/14 and there was no Consolidated Online Registry (COR) screening completed. E. Record review of the employee file for the Staff Development Coordinator (SDC)/Human Resources (HR) revealed that she was hired by the facility on 05/15/14 and there was no Consolidated Online Registry (COR) screening completed. F. Record review of the employee file for CNA #5 revealed that she was hired by the facility on 03/13/14 and there was no Consolidated Online Registry (COR) screening completed prior to employment. G. On 07/28/14 at 1:36 pm during interview with the SDC/HR, she confirmed that all the employee files requested has been submitted. When asked about pre-screening employees for hire, she responded I don't know what they did then, but I know what to do now. H. On 07/28/14 at 3:23 pm during interview with the Regional Director of Operations, he stated, We had identified this during mock survey, this was identified at the end of June. I identified a problem with a screening process and we asked them to devise a plan. That was one of the issues. They were going to complete a sweep and correct it. Since their plan was accepted they still have time to correct it. Findings for employing an individual with past criminal convictions: I. Record review of Personnel Change Notice revealed that the Van Driver (VD) was hired on 12/11/13. J. Record review of New Mexico Department of Health Determination of Employment Disqualifications letter dated 01/25/14 revealed that the VD's, criminal history screening records reflect a disqualifying conviction and, if reconsideration is not requested within fourteen (14) calendar days, this notice requires the referenced applicant/caregiver to be immediately terminated. K. Record review of Employee Counseling/Disciplinary Report dated 07/24/14 revealed that VD was suspended due to, background paper work not in order. L. On 07/29/14 at 3:21 pm during interview with the Director of Nursing, she confirmed that the VD was terminated, not suspended. M. Record review of Operational Policy and Procedure Manual: Background Screening Investigations dated 2001, revised August 2009 revealed: 1. The personnel/human Resource Director, or other designee, will conduct employment background checks, reference checks and criminal conviction checks (including fingerprinting as may be required by state law) on persons making application for employment with this facility. Such investigation will be initiated within two days of employment or offer of employment. 2. Should the background investigation disclose any misrepresentation on the application form or information indicating that the individual has been convicted of abuse, neglect, mistreatment of [REDACTED].
F 0226 **Level of harm** - Immediate jeopardy **Residents Affected** - Many	**Develop policies that prevent mistreatment, neglect, or abuse of residents or theft of resident property.** **Develop policies that prevent mistreatment, neglect, or abuse of residents or theft of resident property.**

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	325059	A. BUILDING _____ B. WING _____	07/29/2014

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ESPANOLA VALLEY NURSING AND REHAB	720 HACIENDA STREET ESPANOLA, NM 87532

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 0226 **Level of harm** - Immediate jeopardy **Residents Affected** - Many	(continued... from page 1) **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility failed to conduct employment background checks and criminal conviction checks prior to offering employment for 6 out of 11 employees. These employees were offered employment before a Consolidated Online Registry (COR) screening was completed. Upon review of these employee records on 07/28/14, the COR had still not been obtained. They also continued to employee the Van Driver (VD) for 6 months after receiving information that revealed he had 2 past criminal convictions that made him ineligible for employment. These deficient practices resulted in an Immediate Jeopardy (IJ) being identified at the facility on 07/28/14 at 4:10 pm. The facility took corrective action by providing an acceptable Plan of Removal. Based on the plan, interventions included doing an audit of currently employed direct caregiver employees to determine if the facility has clearance documentation on file, and any direct caregiver who does not have the documentation will not be allowed to work until clearance has been received by the facility. The facility will obtain required clearance on all new hires prior to the beginning of theri employment, including the COR, OIG Screening and finger print submission within 20 days. Based on the Plan of Removal and observation, the IJ was lifted on 07/28/14 at 4:50 pm. This resulted in the scope and severity being reduced from a scope and severity of L to Level 2, Scope F. Based on record review and interview, the facility failed to follow their policy and procedures regarding background screening investigations by: 1. Not conducting employment background checks and criminal conviction checks prior to offering employment for 6 out of 11 employees reviewed during Abuse Prohibition Review for new employees pre-screening 2. Continuing to employee an individual who had past criminal convictions that made him ineligible for employment for 1 of 11 employees reviewed for Abuse Prohibition Reveiw. If the facility employs individuals with past criminal convictions and is not ensuring that their employees do not have a history of abuse, neglect, exploitation, mistreatment, and misappropriation of property, they put the residents at risk of being victims of abuse, neglect and exploitation. This deficient practice has the potential to affect all 79 residents in the facility, listed on the Resident Census provided by the Minimum Data Set (MDS) Coordinator on 07/20/14. The findings are: A. Record review of Operational Policy and Procedure Manual: Background Screening Investigations dated 2001, revised August 2009 revealed 1. The personnel/human Resource Director, or other designee, will conduct employment background checks, reference checks and criminal conviction checks (including fingerprinting as may be required by state law) on persons making application for employment with this facility. Such investigation will be initiated within two days of employment or offer of employment. 2. Should the background investigation disclose any misrepresentation on the application form or information indicating that the individual has been convicted of abuse, neglect, mistreatment of [REDACTED]. Findings for Pre-screening: B. Record review of the employee file for Certified Nurse Aide (CNA) #3, revealed that she was hired by the facility on 02/24/14 and there was no Consolidated Online Registry (COR) screening completed. C. Record review of the employee file for Registered Nurse (RN) #3, revealed that she was hired by the facility on 01/16/14 and there was no Consolidated Online Registry (COR) screening completed. D. Record review of the employee file for CNA #4 revealed that he was hired by the facility on 05/18/12 and there was no Consolidated Online Registry (COR) screening completed. E. Record review of the employee file for CNA #6, revealed that she was hired by the facility on 04/28/14 and there was no Consolidated Online Registry (COR) screening completed. F. Record review of the employee file for RN #4 revealed that she was hired by the facility on 05/15/14 and there was no Consolidated Online Registry (COR) screening completed. G. Record review of the employee file for CNA #5 revealed that she was hired by the facility on 03/13/14 and there was no Consolidated Online Registry (COR) screening completed prior to employment. H. On 07/28/14 at 1:36 pm during interview with RN #4, she confirmed that all the employee files requested has been submitted. When asked about pre-screening employees for hire, she responded I don't know what they did then, but I know what to do now. I. On 07/28/14 at 3:23 pm during interview with the Regional Director of Operations, he stated We had identified this during mock survey, this was identified at the end of June. I identified a problem with a screening process and we asked them to devise a plan. That was one of the issues. They were going to complete a sweep and correct it. Since their plan was accepted they still have time to correct it. Findings for employing an individual with past criminal convictions: J. Record review of Personnel Change Notice revealed that the Van Driver (VD) was hired on 12/11/13. K. Record review of New Mexico Department of Health Determination of Employment Disqualifications letter dated 01/25/14 revealed that the VD's criminal history screening records reflect a disqualifying conviction and if reconsideration is not requested within fourteen (14) calendar days, this notice requires the referenced applicant/caregiver to be immediately terminated. L. Record review of Employee Counseling/Disciplinary Report dated 07/24/14 revealed that VD was suspended due to background paper work not in order. M. On 07/29/14 at 3:21 pm during interview with the Director of Nursing, she confirmed that the VD was terminated, not suspended.
F 0244 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	**Listen to the resident or family groups or act on their complaints or suggestions.** Based on record review and interview, the facility failed to give the resident council feedback on their concerns which were documented in the resident council meeting minutes. This deficient practice has the potential to affect all 79 residents in the facility, listed on the Resident Census provided by the Minimum Data Set (MDS) Coordinator on 07/20/14, by not providing services that affect the care and lives of the residents in the facility. The findings are: A. On 07/23/14 at 9:08 am during interview with the Dietary Manager, when asked if he had received any resident complaints regarding the food, he stated, During resident council meeting, I do get a report but this is the first one I get in two months. This is the second month I got one. For awhile there was not an activity director, so that may be why. I sometimes get them from (name of SSD) (Social Services Director). She emails them to me if there is a complaint. When asked what is the process after you get a complaint, he responded, What I normally do is see who went to the resident council meeting and find out who the complainant was and I go to the resident. I try to find out if it is just one person. I go to them and do change for that particular issue and then I turn it in to the Administrator, he signs off on it and gives it back to me. If it is a group thing, I actually in-service the staff on what needs to be changed. When asked if the complaints are on a particular form, he responded No, just a concern log or e-mail. B. On 07/24/14 a 3:52 pm during interview with R #16, when asked do you feel that staff follows up on incidents you report, he stated, I don't think so cause nothing is getting done about it. I feel my rights are violated. When asked if he goes to the resident council meetings, he responded, No, not anymore. They just write things on paper and nothing gets done. The aides are good but the higher ups don't listen to complaints or they don't want to listen. C. On 07/25/14 at 11:10 am during interview with R #43 (resident council president), when asked does staff listen to the resident's/councils views and act upon any grievances the resident/group has filed, R #43 responded, I don't know if they act upon it. When asked does appropriate facility staff respond to the complaints the residents/group has filed, R #43 responded, We never know. When asked if the facility does not respond to concerns, do they give a reasonable explanation, R #43 responded, We never get an explanation for anything. D. Record review of Resident Council meeting minutes dated 05/28/14 revealed the following complaints: water, days they get water other days they don't and late, food in kitchen still too much rice, residents would like snacks to be in between meals, residents being left in hall. Resident council meeting minutes did not document any follow up action to the residents' concerns. E. Record review of Resident Council meeting minutes dated 06/02/14 revealed the following complaints: food still an issue, said that they have had complaints for months and no one has done nothing bout (sic) it and that no one from that department has come to talk to him regarding his issue. Said noise at night has been a problem they can't sleep, also (food) alternatives not available. Resident said he needs help to bed at night. Said that residents are been left out in the halls and some residents not being paid attention to. Resident council meeting minutes did not document any follow up action to the residents' concerns. F. Record review of Resident Council meeting minutes dated 07/07/14, revealed the following complaints: food still an issue green beans not being cut, the meat is to tough, to much rice and noodles also that food still being sent that on the ticket, said that the fresh water not getting it til late in the evening, call light still an issue, that no one help residents get to dining room or room that employees just pass them by, bedding hasn't been changed for bout a week, also not making beds, bathroom not being washed, need help getting ready said she being left there after getting out of bed, call light not being answered, nobodys (sic) knocking on door before entering room, one resident is treating (sic) him while he using the phone, money not available when needed, said he hasn't gotten access to his money for six months, said that his things from old room still in there and stuff also missing. Resident council meeting minutes did not document any follow up action to the residents' concerns. G. On 07/25/14 at 5:43 pm during interview with the Activities Director, she confirmed that she takes notes of the resident council meetings. When asked what do you do with the complaints, she responded, We give them to whatever department the issue is with. When asked do you get a follow up from the other departments, she responded, I hadn't. I really don't know that part yet. When asked how do you let the resident know that their complaints are being followed up on, she responded, Sometimes department heads attend the meeting.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	325059	A. BUILDING _____ B. WING _____	07/29/2014

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ESPANOLA VALLEY NURSING AND REHAB	720 HACIENDA STREET ESPANOLA, NM 87532

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 0244 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	(continued... from page 2) Residents sometimes ask for that particular department to attend the meeting. I do not get follow up paperwork from any department.
F 0246 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Reasonably accommodate the needs and preferences of each resident.** Based on observation and interview, the facility failed to ensure that call lights were provided for all 29 residents (R # 4, 7, 12, 27, 30, 43, 45, 59, 63, 64, 65, 67, 76, 83, 85, 86, 87, 91, 93, 95, 98, 106, 111, 115, 116, 133, 134, 135 and 136) identified on the list of residents who are independently ambulatory with and without assistance provided by the Director of Nursing (DON) on 07/26/14. This deficient practice is likely to result in residents being unable to request assistance while in the restroom such as needing help with transferring, after falling or other acute distress. The findings are: A. On 07/22/14 at 1:30 pm during observation of women's restroom in lobby, restroom door was unlocked and no call light cord available. B. On 07/22/14 at 1:33 pm during interview with the Receptionist when asked if residents use women's restroom in lobby, she confirmed that residents are redirected to use other restrooms but, it has happened. C. On 07/29/14 at 9:27 am during observation of women's restroom in lobby, restroom door was unlocked and no call light cord available. D. On 07/29/14 at 10:31 am during interview with the DON, she confirmed that there used to be a lock on the women's restroom about 1 1/2 -2 weeks ago but with the remodel, it was removed but should be replaced. When asked if the residents can use that restroom, she confirmed that they probably could. When asked if a resident went into that restroom and fell , how would staff be aware, she stated, I don't know.
F 0248 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide activities to meet the interests and needs of each resident.** Based on record review and interview the facility failed to provide a program of activities to meet the interests and needs for 1(R#75) of 3 (R# 8, 52 and 75) residents reviewed for activities. A lack of resident centered activities inhibits a residents well being and contributes to a decline in overall functioning. The findings are: A. On 07/23/14 at 3:22 pm, 07/24/14 at 4:45 pm, 07/25/14 at 10:07 pm, 07/25/14 at 9:20 am and 07/25/14 at 2:30 am R #75 was observed in room sleeping. B. On 07/26/14 at 9:48 am, R #75 was observed sitting in a chair in her room. Family Member (FM) #2 was assisting her to eat. C. Record review of care plan for R #75 dated 08/08/13 did not list any resident centered activities. Care plan revealed that R #75 will be, offered schedule of activities for resident to select choices. No activities were listed on the care plan. D. Record review of the activity attendance roster dated 06/01/14 to 07/31/14 revealed that R #75 only attended, care and grooming on 06/21/14, 07/06/14, 07/17/14 and 07/23/14 and no other offered activities. E. On 07/25/14 9:35 am during interview with FM #1, when asked about R #75 activities she stated that she is up during the days but it depends on her mood and she can do activities, she loves music and loves to sing. She likes to dance with her hands, music is her thing, she claps but cant move her legs, she likes to sing. F. On 07/26/14 10:15 am during interview with FM #2 he stated, they don't do things with her and she needs to be taken outside for walks, she likes to sing. G. On 08/07/14 9:40 am during interview with the Activities Director (AD), she stated that R #75, sleeps most of the time, sometimes we take her to class. AD confirmed that if R #75 is taken to an activity the sheet is marked observed. AD confirm that the sheet only reflects 4 activities for 06/01/14 to 07/31/14.
F 0253 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	**Provide housekeeping and maintenance services.** Based on observation and interview, the facility failed to ensure that housekeeping and maintenance services were provided for resident rooms, resident supply rooms, bathing facilities and common areas by not keeping them orderly, sanitary and in good repair. This deficient practice is likely to result in all 79 residents identified on the Alphabetical Census Record provided by the Minimum Data Set (MDS) Coordinator on 07/20/14 being exposed to disease-causing organisms. The findings are. A. On 07/20/14 at 4:15 pm, during an observation of the corridor located between halls 100 and 600, mold was seen on the walls near the cove base (a type of cover at the bottom of a wall). B. On 07/21/14 at 10:38 am and 07/29/14 at 10:13 am, the supply room in the 200 hall located nearest to the nurse's station was inspected. The supply room had an obvious musty odor and had general dirt and debris on the floor including plastic spoons and syringes. Resident care supplies including adult briefs and toiletries were seen to be stored in this room. C. On 07/21/14 at 2:12 pm the supply room on the 400 hall was inspected. The room was supplied with wheelchairs, wheelchair parts, an IV/feeding bag pole (a devise used to elevated bags of medicine and liquid food), fall mats and had a sink area. The room was disorderly and was cluttered with wheelchair parts placed on the floor. The supplies toward the back of the room were not accessible unless the wheelchair supplies toward the front of the room were moved out of the way. The IV/feeding pole was observed to have dirt and grim stuck to it. D. On 07/28/14 at 10:08 am during an interview with Licensed Practical Nurse (LPN) #3, she confirmed that the supply room in the 200 hall located nearest to the nurse's station had a musty, mold like odor. E. On 07/28/14 at 11:09 am during an interview with LPN #2, he confirmed that both of the supply rooms on 200 hall had a foul odor, with the central supply room located nearest to the nurse's station having much more of a strong odor. F. On 07/28/14 at 11:46 am the women's shower room was inspected. The first shower stall on the right hand side as the shower room is entered was observed to have mold on the tile wall and grout located below the shower controls. The shower controls were turned completely off but water continued to leak from the shower controls down the tile wall and grout. G. On 07/28/14 at 11:29 am, the facility's main dining room was inspected. The wall located adjacent to the kitchen was noted to have a large hole in it near the cove base. The drywall around the hole was noted to be broken apart and soggy to the touch H. On 07/29/14 at 10:20 am, room 120 was inspected. The ceiling tiles located in the far corner of the room were observed to have brown water spots. I. On 07/21/14 at 10:20 am during observation of R #50's room, a hole in the wall partly covered by the floorboard was observed. The dry wall was weak and able to be pushed in. J. On 07/29/14 at 10:13 am during interview with RN #2, he stated that he had suspected that there is mold in the storage closet. K. On 07/29/14 at 10:17 am during interview with Central Supply (CS), she stated that when it rains, the supply closet smells musty. L. On 07/29/14 at 10:23 am during interview with R #16, he stated, The water was through the window from the outside. When asked when, he responded, When it rains. M. On 07/29/14 at 10:24 am during interview with Housekeeping (HK) #1 when asked if she has ever seen or suspected mold in the building, she responded, When it's raining, it leaks in the 200 hall from the sprinkler.
F 0272 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Conduct initial and periodic assessments of each resident's functional capacity.** Based on observation, record review and interview, the facility failed to conduct a comprehensive assessment that accurately identified the swallowing and nutritional status using the Minimum Data Set (MDS) for 1 (R #2) of 4 (R # 2, 25, 85 and 111) residents reviewed for nutrition, by not identifying that R #2 was on a mechanically altered diet. This deficient practice is likely to result in residents being incorrectly assessed for identifying and addressing their needs. The findings are: A. Record review of the MDS, Section K: Swallowing/Nutritional Status dated 07/17/14 revealed that R #2 did not have a mechanically altered diet (regular pureed diet). B. Record review of Physicians Orders dated 05/30/14 revealed R #2 was ordered a Regular Pureed Diet. C. Record review of Care Plan dated 12/18/13 revealed that R #2 is on a regular pureed diet. D. On 07/29/14 at 11:05 am during interview with the MDS Coordinator, she stated stated, (name of Dietary Manager (DM)) does section K on the assessment. She confirmed that R #2 is on a regular pureed diet and that it was not coded on the MDS correctly. E. On 07/29/14 at 11:20 am during interview with the DM, he confirmed that Section K on the MDS was coded incorrectly, and stated, (name of R #2) is on a pureed diet.
F 0280 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Allow the resident the right to participate in the planning or revision of the resident's care plan.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to update the comprehensive care plan for 2 (R # 8 and 52) of 3 (R # 8, 11 and 52) residents reviewed for accidents by not identifying new specific interventions to minimize injury from falls after R # 8 and 52 had experienced numerous falls. If care plans are not updated, staff may not be aware of new fall interventions for residents at risk of falls. This deficient practice is also likely to result in increased recurrent falls and possible injury. The findings are: A. Record review of Nursing Services Policy and Procedure Manual: Assessing falls and their causes dated 2001, revised October 2010 revealed When a resident falls, the following information should be

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	325059	A. BUILDING _____ B. WING _____	07/29/2014

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ESPANOLA VALLEY NURSING AND REHAB	720 HACIENDA STREET ESPANOLA, NM 87532

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 0280 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 3) recorded in the resident's medical record: Appropriate interventions taken to prevent future falls. Findings for R #52: B. Record review of Facility Incident log revealed that R #52 had 24 (twenty-four) falls from 09/20/13 through 07/23/14 on the following dates: 09/20/13 6:20 am found on floor 09/26/13 1:45 pm fall>environmental 10/13/13 unknown found on floor 10/20/13 unknown found on floor 10/26/13 unknown found on floor 11/12/13 1:50 am fall>environmental 11/14/13 6:00 pm Px (prognosis) contact - res (resident) 12/20/13 3:15 pm found on floor 12/24/13 4:11 pm found on floor 01/15/14 6:48 am fall/no head injury 02/10/14 5:00 am found on floor 03/28/14 1:51 pm found on floor 05/07/14 6:30 pm found on floor 06/05/14 4:13 pm found on floor 06/06/14 11:45 am fall w/head injury 06/12/14 4:00 pm fall - unobserved 06/13/14 2:00 pm fall - unobserved 06/14/14 9:30 am found on floor 06/16/14 2:31 am found on floor 06/16/14 9:15 pm found on floor 06/20/14 8:01 pm found on floor 06/26/14 11:45 pm found on floor 07/01/14 12:29 am found on floor 07/12/14 6:00 pm skin tear - superficial C. Record review of the Care Plan for R #52 regarding falls, revealed the following interventions updates: 1. 09/26/13, 10/14/13, 10/21/13, 10/28/13, 11/13/13, therapy screen 2. 02/12/14, 06/05/14, 06/13/14, 06/16/14, 06/27/14: Unavoidable fall form 3. 01/14/14, 03/31/14, 05/07/14: Interventions appropriate D. Record review of Physical Therapy Screening form revealed that on 10/29/13, 06/05/14, 06/12/14, 06/16/14, 06/20/14: no therapy was recommended. E. Record review of the Unavoidable Fall Form for R #52 dated 06/06/14 revealed that due to medical conditions, functional impairments and the following interventions tried unsuccessfully in 2012: Therapy, Restorative programs, environmental modifications/assistive devices, resident/family education and restraints, the Detemination of unavoidable is made only when appropriate preventative measures are tried and deemed unsuccessful. F. On 07/27/14 at 10:25 am during interview with the Director of Nursing, she stated She also has an Unavoidable Fall Form in her file which states that we have tried interventions and she is more than likely to fall. Which means we continue to do interventions and the doctors are aware that there will still be unavoidable falls. Most of these falls, the interventions were appropriate. What I mean by that is that we find her on her mat. But we still have to document it as a fall. G. On 07/22/14 at 11:03 am during interview with Family Member #3, he stated that his mother has fallen atleast a dozen times. He stated that the facility does all these things but nothing seems to work. He stated that when R #52 was in the other room on the 500 hall, her roommate took better care of her than the nurses did because the roommate would call the nurses when R #52 would fall. He stated that he comes to the facility everyday and tries to stay from about 7:00 am until noon, then he has to go to work. He stated that he couldn't take care of her himself because he has to work. FM #3 expressed concern that the level of R #52's care would decrease because he was talking to the surveyor. Findings for R #8: H. Record review of Facility Incident log revealed that R #8 was found on the floor on the following dates: 03/27/14, 04/15/14, 05/06/14, 05/14/14, 05/17/14, 05/20/14 and 07/21/14. I. Record review of the Care Plan for R #8 revealed the following intervention updates: 03/31/14 Encouraged to ask for assistance. 04/16/14 Pressure alarm to bed + (and) w/c (wheelchair). Dc'd (Discontinued) 05/14/14. 05/07/14 Encourage to ask for assistance 05/14/14 Tab alarm to bed + w/c J. Record review of Physician order [REDACTED]. K. Record review of Therapy Screening Form for R #8 dated 07/22/14 revealed that no therapy was not recommended and made the following comments: Encourage/educate res (resident) to use call light to ask for assistance. Educate resident to not transfer self. L. On 07/24/14 at 10:09 am during interview with the Director of Nursing when asked what interventions have been initiated since her most recent fall on 07/21/14, she responded Nothing since her most recent fall. We are still pending her therapy screen. M. On 07/25/14 at 9:30 am during interview with Certified Nurse Aide (CNA) #1 when asked if there are any fall precautions or interventions for R # 8, she responded, I don't know. N. On 07/25/14 at 9:55 am during interview with Physical Therapist #1, when asked if R #8 is a fall risk, he responded For ambulation, she would be. I haven't been brought in. I'm not aware of any falls. If there are any falls, we do get a report of that and we would look at what is going on and make recommendations. We would look at the height of the bed or putting skid strips on the floor. When informed that resident has had 7 falls since admission, he responded I would sure like to know about that. O. On 07/25/14 at 12:54 pm during interview with Registered Nurse #1 when asked if R #8 is a fall risk, she responded Yes. When asked what interventions have been put in place, she responded, She's reminded constantly to use her call button. Persistent reminders verbally to call staff and ask for help. That is what we do. She is alert. Somedays she's more with it than other days. There are days- if she's having an off day. She might repeatedly stand up from the wheelchair and not ask for help. Consistent reminders. Based on record review and interview the facility failed to use the results of the comprehensive Minimum Data Set (MDS) assessment to revise comprehensive plan of care for 1 (R #76) of 7 (R #4, 48, 69, 76, 82, 83 and 88) residents review for activities of daily living. If the facility does not revise a residents comprehensive care plan to reflect changes in level of function residents are a risk for not getting the care they need to thrive. The findings are: A. Record review of MDS dated [DATE] for R #76 was coded for Activities of Daily Living as requiring oversight, encouragement or cueing and/or requiring no help or staff oversight at anytime during meals. B. Record review of MDS dated [DATE] and 07/07/14 for resident #76 was coded for Activities of Daily Living as requiring extensive assistance during meals. C. Record review of care plan for R #76 dated 07/08/14 stated that dining will require setup, cue and assist as needed with ADLs. D. On 07/24/14 at 10:36 am during interview with the MDS coordinator, confirmed that the MDS record reflected a change of function from, cueing to extensive assistance. MDS Coordinator then confirmed that the care plan, was not updated. MDS coordinator stated that the, care plan is updated per policy but this one was overlooked. E. On 07/24/14 at 12:12 pm during observation, R #76 was in the dining area eating lunch without assistance and stated that, the meat is overcooked. Based on record review and interview, the facility failed to update the care plan to reflect that 1 (R #2) of 4 (R # 2, 25, 85 and 111) residents reviewed for nutrition, was ordered honey thickened liquids. If the care plan is not updated to reflect diet order changes, staff may not be aware that the resident requires a different liquid consistency, which could put the resident at risk of choking, lung infections and/or death. The findings are: A. Record review of the Physicians Order for R #2 dated 03/10/14 revealed that resident was ordered honey thickened liquids. B. Record review of the Care Plan dated 12/18/13 did not indicate that R #2 was ordered honey thickened liquids. C. On 07/29/14 at 11:37 am during interview with the Dietary Manager, when asked if care plans should indicate that a resident is on thickened liquids, he responded I haven't been but they should be.
F 0282 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide care by qualified persons according to each resident's written plan of care.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to implement the care plan by not reviewing the effectiveness of the antipsychotic medication [MEDICATION NAME] at least quarterly for 1 (R #72) of 5 (R #3, 59, 69, 72, 84) residents reviewed for unnecessary medications. If the facility does not review the effectiveness of the medication at least quarterly, the facility is unable to determine whether or not there is a continued need for the medication. This deficient practice is likely to cause the resident to continue to receive the medication unnecessarily, which could result in the resident experiencing side effects. The findings are: A. Record review of the care plan for R #72 dated 12/19/13 noted Risk for complication r/t (related to) [MEDICAL CONDITION] meds (medications) (Name of R #72) is prescribed a routine & PRN (as needed) antispychotic; IDT (Interdisciplinary Team) review of effectiveness of medication regimen at least quarterly and PRN. B. On 07/28/14 at 2:00 pm, during interview, the Minimum Data Set (MDS) Coordinator confirmed that they are not conducting quarterly assessments for [MEDICAL CONDITION] medications. C. On 07/29/14 at 2:42 pm, during interview, the Director of Nursing confirmed that they are not conducting quarterly assessments. Based on record review and interview, the facility failed to ensure that services were provided in accoradance with the resident's plan of care for 1(R #8) of 3 (R #8, 25 and 85) residents reviewed for rehabilitation by not providing restorative services to R #8's lower extremities. This deficient practice is likely to result in residents identified as a fall risk to continue to fall due to decreased strength and endurance during transfers, which could result in bruises, lacerations, broken bones, head trauma and death. The findings are: A. Record review of Physician order [REDACTED]. B. Record review of Care Plan dated 07/21/14 revealed, Restorative program 5 days a week for UE and LE strength and general endurance. C. Record review of the Nursing Restorative Care Program dated July 2014 revealed, Goals: 1. To maintain strength in bilateral UE's 2. To maintain overall general endurance 3. Optimal LE strength. Appraoches with Frequency: 1. Arm bike 2. 2 lb (pound) weights + (and) reverse curls- 10 reps (repetitions) x (times) 5 sets. D. On 07/24/14 at 12:29 pm

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	325059	A. BUILDING _____ B. WING _____	07/29/2014

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ESPANOLA VALLEY NURSING AND REHAB	720 HACIENDA STREET ESPANOLA, NM 87532

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 0282 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 4) during interview with Restorative Aide #2, she stated, The program they gave us was upper extremity. She confirmed that she has not been doing lower extremity exercises with R #8. E. On 07/28/14 at 12:09 pm during interview with Physical Therapist #1 when asked about the Restorative Order for UE and LE strengthening, he confirmed that there is a goal listed for LE strengthening however there are no approaches listed for LE exercises for the month of July. PT #1 confirmed that the order had not been changed, and there should be approaches listed and implemented for LE exercises.
F 0311 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Make sure that residents receive treatment/services to not only continue, but improve the ability to care for themselves.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to provide appropriate services to maintain and/or improve the functional abilities for 1(R #8) of 3 (R #8, 25 and 85) residents reviewed for rehabilitation by not providing restorative services to R #8's lower extremities. This deficient practice is likely to result in residents identified as a fall risk to continue to fall due to decreased strength and endurance during transfers, which could result in bruises, lacerations, broken bones, head trauma and death. The findings are: A. Record review of Physician order [REDACTED]. B. Record review of Care Plan dated 07/21/14 revealed, Restorative program 5 days a week for UE and LE strength and general endurance. C. Record review of the Nursing Restorative Care Program dated July 2014 revealed Goals: 1. To maintain strength in bilateral UE's 2. To maintain overall general endurance 3. Optimal LE strength. Appraoches with Frequency: 1. Arm bike 2. 2 lb (pound) weights + (and) reverse curls- 10 reps (repetitions) x (times) 5 sets. D. On 07/24/14 at 12:29 pm during interview with Restorative Aide #2, she stated, The program they gave us was upper extremity. She confirmed that she has not been doing lower extremity exercises with R #8. E. On 07/28/14 at 12:09 pm during interview with Physical Therapist #1 when asked about the Restorative Order for UE and LE strengthening, he confirmed that there is a goal listed for LE strengthening, however there are no approaches listed for LE exercises for the month of July. PT #1 confirmed that the order had not been changed, and there should be approaches listed and implemented for LE exercises.
F 0315 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Make sure that each resident who enters the nursing home without a catheter is not given a catheter, and receive proper services to prevent urinary tract infections and restore normal bladder function.** Based on observation, interview and record review the facility failed to ensure that proper catheter care to prevent urinary tract infections for 1 (R #51) of 1 (R #51) residents observed during random observation by placing the resident's urinary catheter drainage bag on the bare ground. This deficient practice is likely to result in residents who have urinary catheters acquiring urinary tract infections. The findings are: A. Record review of the facility's Policy and Procedure on Urinary Catheter Care - Infection Control dated October 2010, revealed that urinary catheter drainage bags are to be kept off of the floor. B. On 07/26/14 at 11:40 pm, during an interview with Licensed Practical Nurse (LPN) #1 she confirmed that a resident's catheter drainage bag should not touch bare floor due to infection control concerns. LPN #1 confirmed that when a resident has a urinary catheter and a low bed the catheter drainage bag should be placed in a position low enough to allow for drainage but not so low as to allow the drainage bag to touch the floor. C. On 07/25/14 at 2:29 pm and 2:41 pm R #51 was observed to be sleeping with the bed in the lowest position. The resident's urinary catheter bag was observed hanging from the side of the bed and touching the bare floor. D. On 07/28/14 at 10:09 am R #51 was observed to be sleeping with the bed in the lowest position. The resident's urinary catheter bag was observed hanging from the side of the bed and touching the bare floor.
F 0323 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	**Make sure that the nursing home area is free from accident hazards and risks and provides supervision to prevent avoidable accidents** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility failed to ensure that residents were free from reoccurring falls by facility staff not being aware that R #8 required extensive one-person assist for transferring and toiletting and R #8 continued to transfer herself unassisted and would fall. R #8 and R #52 continued to have numerous falls within the facility and new interventions were not being implemented to prevent future falls. R #8 was found on the floor on 07/21/14 and the facility's response was to discontinue her tab alarm and continue to encourage R #8 to ask for assistance. These deficient practices resulted in an Immediate Jeopardy (IJ) being identified at the facility on 07/25/14 at 1:45 pm. The facility Administrator and Director of Nursing was notified at this time. The facility took corrective action by providing an acceptable Plan of Removal. Based on the plan, interventions included inservicing evening and night shift staff on 07/25/14 on the following: 1. Residents who are at risk for falling. 2. Interventions which are in place for that resident. 3. No staff member will be allowed to work until they have completed the re-education for fall risk residents. 4. A list of residents who have been identified as fall risk will be placed at the nurse's station. 5. Re-education for staff members will continue on 07/26/14 until completion. Based on the Plan of Removal and observation, the IJ was lifted on 07/25/14 at 6:25 pm. This resulted in the scope and severity being reduced from a scope and severity of K to Level 2, Scope E. Based on record review and interview the facility failed to ensure that residents are free from accidents for 2 (R # 8 and 52) of 3 (R # 8, 11 and 52) residents reviewed for accidents by: 1. Staff not aware that R #8 requires extensive one person assist for transfers and toileting. 2. New interventions to prevent falls were not implemented after R #8 and R #52 continued to have numerous falls. 3. Not providing restorative services for R #8 to improve strength and endurance If staff is not aware of the resident's transfers needs, new interventions are not being implemented after a resident falls, and resident are not receiving ordered therapy services to improve strength and endurance, residents are at an increased risk for recurrent falls which could result in bruises, lacerations, fractures, head trauma and death. The findings are: Findings for R #52: A. On 07/22/14 at 11:03 am during interview with Family Member #3, he stated that his mother has fallen at least a dozen times. He stated that the facility, does all these things but nothing seems to work. He stated that when R #52 was in the other room on the 500 hall, her roommate took better care of her than the nurses did because the roommate would call the nurses when R #52 would fall. He stated that he comes to the facility everyday and tries to stay from about 7:00 am until noon, then he has to go to work. He stated that he couldn't take care of her himself because he has to work. FM #3 expressed concern that the level of R #52's care would decrease because he was talking to the surveyor. B. On 07/27/14 at 10:03 am during interview with the Assistant Director of Nursing (ADON) when asked what interventions have been put in place to prevent R # 52 from falling, she responded, We've tried lap buddies, velcro belt (wasn't effective), hi/lo bed with mat on floor, tab alarms (she tends to remove it). She currently has a pressure alarm (it's been somewhat effective). She has been moved to a room closest to DON (Director of Nursing) Define preceding colored. /ADON's office. We've also initiated a bowel and bladder program because it may have been that she was trying to get up to toilet herself. DON has had a discussion with the doctors MD (Medical Doctor) Define preceding colored. #1 and MD #2) because of restless leg syndrome - notified physician - to see if there was anything that could be done in regards to her anxiety. Doctor has prescribed Ativan (PRN - as needed) for anxiety. She is also on hospice. We notify and communicate with the doctor and nurses from Hospice - (Name of hospice agency) - and see if they have any suggestions. The discussion included a conversation with R #52's son. R #52's son has suggested using a restraint. All parties agreed to use the lap buddy (Facility, (Name of hospice agency) Hospice caregivers and R #52's son). Some of the issues were that she'd have sliding issues in wheelchair. Facility tried a pommel cushion (a vinyl cushion used for a wheelchair to prevent resident from slipping) for the wheelchair to see if that worked. MD #1 filled out an 'Unavoidable Fall Form.' In the care plan it recognizes that she will have unavoidable falls, so the plan is to see what can be done to keep her safe. In regards to R #52's son's recommendation to use restraints, we spoke to him and let him know that we are trying to use the least restrictive device to keep R #52 safe. C. On 07/27/14 at 10:25 am during interview with the DON, when asked what interventions have been used to prevent R # 52 from falling, she responded, When (name of R #52) first came to the facility she was still partially ambulatory. She has progressed dementia. One of the reasons she came to us was because of her falls and her son was unable to care for her. Since then (even when she came to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	325059	A. BUILDING _____ B. WING _____	07/29/2014

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ESPANOLA VALLEY NURSING AND REHAB	720 HACIENDA STREET ESPANOLA, NM 87532

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 0323 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 5) us) her vision is very diminished. She has seen numerous doctors and there is nothing they can do. She is also severe hard of hearing. As far as interventions, we have tried to move her closer to the nurse's stations - she was in a different hall. First we tried non-skid strips; from her bed to the bathroom in her old room. She did fall and she sustained a fracture to one of her hips. While she was on the hall she was still low bed with bed against the wall. She was also on a tab alarm. We've tried a pressure alarm. She was on therapy (occupational and physical therapy). We have used a clip belt alarm which she could remove - and she did. We've used a lap buddy at different times. She's had her bed against the wall on the right side. She's on a low bed with mat to floor. The doctors have done medication reviews (MD #1 and MD #2 - with (Name of hospice agency) Hospice). She is on hospice. Her son is always here. She also has an Unavoidable Fall Form in her file which states that we have tried interventions and she is more than likely to fall. Which means we continue to do interventions and the doctors are aware that there will still be unavoidable falls. We've sent her to eye appointments. We've tried nursing interventions - CNAs sit with her. She knows someone is present but she can't see. Most of these falls the interventions were appropriate. What I mean by that is that we find her on her mat. But we still have to document it as a fall. D. Record review of Facility Incident log revealed that R #52 had 24 (twenty-four) falls from 09/20/13 through 07/23/14 on the following dates: 09/20/13 6:20 am found on floor 09/26/13 1:45 pm fall>environmental 10/13/13 unknown found on floor 10/20/13 unknown found on floor 10/26/13 unknown found on floor 11/12/13 1:50 am fall>environmental 11/14/13 6:00 pm Px (prognosis) contact - res (resident) 12/20/13 3:15 pm found on floor 12/24/13 4:11 pm found on floor 01/15/14 6:48 am fall/no head injury 02/10/14 5:00 am found on floor 03/28/14 1:51 pm found on floor 05/07/14 6:30 pm found on floor 06/05/14 4:13 pm found on floor 06/06/14 11:45 am fall w/head injury 06/12/14 4:00 pm fall - unobserved 06/13/14 2:00 pm fall - unobserved 06/14/14 9:30 am found on floor 06/16/14 2:31 am found on floor 06/16/14 9:15 pm found on floor 06/20/14 8:01 pm found on floor 06/26/14 11:45 pm found on floor 07/01/14 12:29 am found on floor 07/12/14 6:00 pm skin tear - superficial E. Record review of Physical Therapy Screening form for R #52 revealed: 1. 06/20/14 FALL. Resident (R #52) found on the floor next to her bed. CNA responded to the alarm. The patient has hi/lo bed and padded mat at bedside. No therapy was recommended (OT, PT or ST). Comments: Resident has cognition deficits. Resident (R #52) is on hospice services. Continue to monitor and respond as needed. 2. 06/05/14 FALL. Found on the floor by CNA sitting on mat with back against bed wheelchair flipped on side. Appears resident (R #52) was transferring self to bed and fell . Did not strike head. Comments: Continue to monitor resident. Avoid leaving (name of R #52) in room unattended. Assist (name of R #52) to bed as needed. 3. 06/16/14 Fall - resident (R #52) found on the floor next to foot of bed. Resident (R #52) complained of pain. Has goose egg bump on left side of forehead. No therapy recommended. Comments: PRN (as needed) Lortab administered per MAR (Medication Administration Record). Continue to monitor resident (R #52) on hospice services. Monitor alarm to make sure it is in place and plugged in. 4. 06/14/14 resident (R #52) found on floor off of mat. Increased anxiousness/past 3 days. No therapy recommended. COMMENTS: Ativan given for anxiousness. Hospice aware of situation. Calls were done for past 3 incidents. 5. 06/12/14 fall - resident (R #52) found on floor by another resident. Resident (R #52) lying on floor next to mat in patient's room. No evidence of injury. No therapy recommended. COMMENTS: Resident (R #52) to be monitored more closely. 6.10/29/13 resident (R #52) was found with upper body on mat and lower body on floor. (Name of hospice agency) and (R #52's) son were notified. Make sure patient has alarm on and functioning at all times. F. Record review of Physical Therapy Screening form revealed that on 10/29/13, 06/05/14, 06/12/14, 06/16/14, 06/20/14: no therapy was recommended. G. Record review of Occupational Therapy Assessments revealed: 1. 03/14/14 R # 52 fell on [DATE] (name of R #52) observed on floor next to bed by CNA. Results of screen: (name of R #52) to have bed alarm at all times. 5:00 am early make sure frequent rounds are done to ensure (name of R #52) safety. 2. 03/31/14 R #52 fell on [DATE]. (name of R #52) found on floor in room by CNA. Results of screen: Tab alarm to be applied to bed/wheelchair. Make sure mat to floor is applied to prevent injury. H. Record review of R #52's care plan revealed, problem onset is dated 09/19/13. Risk for injury r/t (related to) falls AEB (as evidenced by): (name of resident) has a hx (history) of falls, requires total one person assist with toileting, transfers, bed mobility, has impaired balance and is occasionally incontinent of bowel & bladder with additional risk r/t (related to) generalized pain, muscle weakness, anxiety, hypertension, anxiety and depression. Next entry on R #52's care plan is dated 07/01/14, observed on floor. Redness to back. Approach for this problem: 07/02/14 Hospice provided new w/c (wheelchair). Unavoidable fall form in place. I. Record review of the Care Plan for R #52 regarding falls, revealed the following interventions updates: 1. 09/26/13, 10/14/13, 10/21/13, 10/28/13, 11/13/13, therapy screen 2. 02/12/14, 06/05/14, 06/13/14, 06/16/14, 06/27/14: Unavoidable fall form 3. 01/14/14, 03/31/14, 05/07/14: Interventions appropriate J. Record review of the Unavoidable Fall Form for R #52 dated 06/06/14 revealed that due to medical conditions, functional impairments and the following interventions tried unsuccessfully in 2012: Therapy, Restorative programs, environmental modifications/assistive devices, resident/family education and restraints, the Determination of unavoidable is made only when appropriate preventative measures are tried and deemed unsuccessful. K. Record Review of Falls/I & A (Incident & Accident) Committee Meeting Minutes revealed: 09/14/13 Observed on floor, no injury, room close to nurses station, therapy screen. 09/20/13 Transferred from w/c (wheelchair) and fell to floor unassisted. Intervention Therapy screen, in-serviced staff not to leave resident unattended. 09/26/13 Rsd found on floor. sent to ER (emergency room), Therapy screen, pain management/f/uc ortho. 10/26/13 Found on floor in room, no injury, sign made to notify staff. When care not done leave curtain open, therapy screen. 10/20/13 Unavoidable fall form. Therapy screen, found on floor. 10/18/13 Therapy screen, activities screen for individual activity. 11/12/13 Staff inserviced not to leave resident in her room up in w/c (wheelchair) 12/20/13 Resident found on mat, Intervention appropriate. 01/15/14 Found on mat, Interventions appropriate. 01/15/14 Found on floor, All intervention exhausted. 01/15/14 Found on mat, Interventions appropriate. 02/10/14 Resident found on floor, sent to ER (emergency room), unavoidable fall form neuro checks. 06/06/14 Son pushed resident. Resident fell son was talked to. No injury, neuro checks, unavoidable fall form. 06/05/14 Resident tried to transfer self found on mat on floor. Unavoidable fall form. 06/12/14 Found on floor, medication review for increased anxiety. 06/13/14 Found on floor, no injury/unavoidable fall. 06/14/14 Found on floor, no injury/unavoidable fall. 06/16/14 Found on floor bump to left forehead neuro checks/medication review unavoidable fall form. 06/16/14 Found on floor, clip belt change to lap buddy. 06/20/14 Found on floor, unavoidable fall form/pressure alarm replaced. 06/26/14 Found on floor in room, swollen eye, unavoidable fall form, neuro checks. 07/01/14 Resident fell in DR (dining room). lap buddy to side. 07/01/14 Found on floor in DR (dining room), unavoidable fall. Hospice brought new wheelchair. L. Record review of Post Incident actions revealed: 01/15/14 Res was found on mat beside her bed. bed alarm did not go off. 06/16/14 Res bed alarm was in place on bed but cord was not plugged in. Findings for R #8: M. Record review of Facility Incident log revealed that resident was found on the floor on the following dates: 03/27/14, 04/15/14, 05/06/14, 05/14/14, 05/17/14, 05/20/14 and 07/21/14. N. Record review of Progress Notes revealed: 03/27/14 CNA found resident on floor of bathroom. 03/31/14 Resident seen in IDT for falls on 03/27/14. Resident on therapy caseload. Encouraged to ask for assistance. No injury noted. 04/16/14 New orders for pressure alarm to bed and wheelchair. Instruct CNA to put shoes on resident when awake. 04/16/14 Res was found sitting on the floor next to her room in the hall way with the wheelchair at the door. Res stated that she just felt like walking and slid on her bottom. 05/07/14 Resident found on floor in room on blanket on 05/06/14. She stated she did not fall and sat on floor to do exercises. Encouraged to ask for assistance. 05/14/14 Resident seen in IDT resident will be placed a tab alarm to bed and wheelchair. 05/20/14 resident found on floor in bathroom. 05/21/14 Resident refuses to wear a tab alarm. Resident takes tab alarm off when in place. 05/23/14 Late entry for 05/17/14- Res found on the floor in her room. She stated to staff that she did not fall. 07/21/14 Res found on floor of room, states that she slipped from w/c while transferring without assist. 07/22/14 Tab alarm DC'd resident removes alarm and hides it. O. Record review of Fall Risk Data Set date 06/23/14 revealed that resident is a high risk for falls. P. Record review of R #8's ADL's Prior to being admitted to Nursing Home assessment dated [DATE] revealed resident requires 1:1 (one on one) assist with mobility and ambulation and requires frequent but not hands on assist with dressing/grooming, requires 1:1 continuously assist with transferring, and Requires assist, but can be left alone for privacy with toiletting. Q. Record review of Care Plan revealed: 1. 04/04/14 Risk for injury r/t (related to) Falls AEB (as evidenced by): (name of R #8) has impaired balance, requires extensive one person assist with transfers, bed mobility, toileting with additional risk r/t falls, depression, anxiety, dementia, muscle weakness, and late effect cerebralvascular disease. a. 03/27/14 Observed on floor 0 (no) injury. b. 04/15/14 observed on floor 0 injury. c. 05/06/14 observed on floor 0 injury. d. 05/14/14 observed on floor. e. 05/20/14 observed on floor, redness to L (left) armpit. Approaches: Ruled out medical complications [REDACTED]. Periodic medication Review. Ensure safe environment, free of clutter, adequate lighting, clean spills promptly. Transfer with assist of one person. Fall assessment on admission,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	325059	A. BUILDING _____ B. WING _____	07/29/2014

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ESPANOLA VALLEY NURSING AND REHAB	720 HACIENDA STREET ESPANOLA, NM 87532

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 0323 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 6) quarterly and with changes in falls. Ensure appropriate footwear when OOB (out of bed). Call bell in reach. Provide adequate lighting. Clean and apply glasses daily as appropriate; ophthalmology referrals as deemed necessary. PT (Physical Therapy) eval(evaluation)/tx (treatment) as indicated. 2. 07/21/14 Risk for injury r/t Falls AEB impaired cognition resident transferring self with out assistance. Resident was found on floor states she slipped while transferring self. Approaches: Notify MD and family of falls or injuries. Ensure safe environment, free of clutter, adequate lighting, clean spills promptly. Restorative Program 5 days/ week for UE (Upper Extremity) and LE (Lower extremity) strength and general endurance. Ensure appropriate footwear when OOB. Call bell in reach. PT eval/tx (treatment) as indicated. 3. 04/04/14 Alteration in elimination AEB: (name of R #8) requires extensive one person assist with toileting and transfers. 4. 04/04/14 Self care deficit AEB: (name of R #8) requires extensive one person assist with bathing, bed mobility, transfers, locomotion, dressing, eating, toileting, and personal hygiene. R. Record review of the Care Plan for R #8 revealed the following intervention updates for falls: 03/31/14 Encouraged to ask for assistance. 04/16/14 Pressure alarm to bed + (and) w/c (wheelchair). Dc'd (Discontinued) 05/14/14. 05/07/14 Encourage to ask for assistance 05/14/14 Tab alarm to bed + w/c S. Record review of Physician order [REDACTED]. T. On 07/21/14 at 2:04 pm during interview with Licensed Practical Nurse #3 she stated, At 6:25 am this morning- they found her sitting next to her chair- she said she was transferring to the restroom. U. On 07/24/14 at 10:09 am during interview with the DON when asked if resident is a fall risk, she responded, Yes, but when she was with therapy she was able to transfer herself. When asked if she could transfer herself currently, she responded She attempts to transfer herself with staff assist. She's weight bearing. One person assist. When asked what interventions are being done to prevent falls, she responded, We use tab alarms and pressure alarms and she likes to hide them and take them off. On 03/27 (2014) she was encouraged to ask for assist. On 4/15 (2014) placed pressure alarms to bed and wheel chair. On 5/14 (2014) we changed it to a tab alarm. She's on the restorative program for upper and lower strengthening and general endurance. They dc'd her tab alarm. When asked why her tab alarm was discontinued, she responded, Because she removes it and hides it. When asked what interventions have been initiated since her most recent fall on 07/21/14, she responded, Nothing since her most recent fall. We are still pending her therapy screen. V. Record review of Therapy Screening Form for R #8 dated 07/22/14 revealed that no therapy was not recommended and made the following comments: Encourage/educate res (resident) to use call light to ask for assistance. Educate resident to not transfer self. W. Record review of Physician order [REDACTED]. X. On 07/24/14 at 12:29 pm during interview with Restorative Aide #1, she stated, The program they gave us was upper extremity. She confirmed that she has been doing no lower extremity stuff with (name of R # 8). Y. On 07/28/14 at 12:09 pm during interview with Physical Therapist #1 when asked about the Restorative Order for UE and LE strengthening, he confirmed that there is a goal listed for LE strengthening, however there are no approaches listed for LE exercises for the month of July. PT #1 confirmed that the order had not been changed, and there should be approaches listed and implemented for LE exercises. Z. On 07/24/14 at 3:24 pm during interview with Social Services Director when asked about resident's falls, she responded, She came in and she came in on physical therapy. She was not actively participating. She has been on restorative walk to dine program but she uses her wheelchair. Her posture is such that it's a risk situation. The request (for restorative) was made by the doctor and few weeks ago. She may have been declined to walk too. I think she does understand that she needs 24/7 care now. She's a fall risk. That's what brought her to us. She doesn't want anyone to know she falls. The safety issues are huge. AA. Record review of Physical Therapy Recertification and Updated Plan of Treatment dated 05/28/14 revealed Instruction: Safety training in having assistance for all transfers. BB. On 07/25/14 at 9:30 am during interview with Certified Nurse Aide (CNA) #1, she stated, She is really independent. She can transfer herself and she can toilet herself. I check on her periodically. I try to check on her as often as I can- once an hour and every 2 hours. When asked if resident needs assistance in the restroom, she responded, She does it by herself. When asked if resident needs assistance with transferring, she responded No. When asked if resident is a fall risk, she responded No, she's not. When asked if there are any fall precautions or interventions, she responded, I don't know. CC. On 07/25/14 at 9:38 am during interview with R #8 she stated, They are suppose to help me get dressed and they didn't. Then they get mad at me cause I'm so late getting up. When asked if she needs assistance in going to the restroom, she responded, No. I learn how to get up and do it by myself. When asked if she has had any falls, she responded, I fall a lot of times in the bathroom, when I try to sit on the potty. When asked if staff helps her in the restroom, she responded, The men do. I don't like that. When asked if the woman help her, she stated, No. They put all those things (alarms) on me but they (staff) never come. DD. On 07/25/14 at 9:42 am during interview with CNA #2 when asked what kind of assistance the resident needs, she responded, She just basically needs verbal assistance. She can do a lot of things for herself. When asked if she needs assistance in transferring, she responded, At times but not all the time- just stand by. When asked if resident can take herself to the restroom, she responded, Yes. When asked if resident uses the call light, she responded, Yes, every once in a long time. When asked how often they check on her, she responded We pass the hallway every 10 to 15 minutes. Most of the time she's sitting by her door and she'll ask. When asked if the resident is a fall risk, she responded, I don't think so. In my eyes everyone is. Right now she has a tab alarm. When asked if the resident has had any falls, she responded I don't know. She's always in her wheelchair. When asked if resident takes herself to the restroom, she responded, She really at times doesn't like for us to help her. She can pretty much do it by herself. If we turn our back for a minute, she'll go to the bathroom by herself. That's probably why she has her tab alarm. EE. On 07/25/14 at 9:49 am, during interview with Occupational Therapist #1, he confirmed that he is no longer working with the resident, She has some real cognitive deficits that prevent her from being more independent. She doesn't really initiate tasks. Once you tell her she's able to. She's not safe for ambulation on her own. She'll lose focus. When asked if resident is able to transfer herself, he responded Not a good idea. Physically she's able to do it, but she loses focus. Her brain just., she won't say anything but there goes her vision and she's looking somewhere else. It doesn't happen all the time. FF. On 07/25/14 at 9:55 am during interview with Physical Therapist #1, he stated, We were doing strengthening, safety. We attempted some gait training. I would say fair- she had a lot of behaviors dementia like things that would interfere with the training. As far as the gait training- she bent at a 90 degree angle when she walked which was very unsafe. We did suggest a restorative program. I have been asked about a walking program but I thought that would be unsafe. When asked if the resident is able to transfer herself, he responded She was at the time. When asked if she needs assistance from staff, he responded, Supervision for safety. Her safety judgement was not the greatest. She was able to transfer independently but safety was an issue. When asked if resident was a fall risk, she responded, For ambulation, she would be. I haven't been brought in. I'm not aware of any falls. If there are any falls, we do get a report of that and we would look at what is going on and make recommendations. We would look at the height of the bed or putting skid strips on the floor. When informed that resident has had 7 falls since admission, he responded, I would sure like to know about that. GG. On 07/25/14 at 12:54 pm during interview with Registered Nurse (RN) #1 when asked what kind of assistance resident needs, she responded, I would say minimal assist. She does need some assist at times. Her level of care is dependant on her mood- of the day. Some days she's really independent and she wants to do things herself. When asked what kind of things, she needs assistance with, she responded, Primarily dressing, sometimes transferring to the toilet. She's able to wheel herself in the wheelchair. When asked if she needs toileting assistance, she responded, Minimal, at times. It's not consistent help. When asked if resident is a fall risk, she responded, Yes. When asked what interventions have been put in place, she responded, She's reminded constantly to use her call button. Persistent reminders verbally to call staff and ask for help. That is what we do. She is alert. Somedays she's more with it than other days. There are days- if she's having an off day. She might repeatedly stand up from the wheelchair and not ask for help. Consistent reminders. When asked if she has had falls, she responded, That I know of for sure is 3. I think she's had more than 3 but what I know of is 3. Once when she first came she fell in the bathroom. The other time I know of she fell in this hallway. The time in the bathroom was her first day she was agitated and angry about being here, wanted to go home and hated us for sure. The time she fell in the hallway, she was in a fairly good mood that night but she was trying to reach for something from her wheelchair. When we found her, her wheelchair was right outside her door and we found her next to her wheelchair. When I've been around and she's falling, it seems to be confusion. She thinks that she needs to go somewhere. She thinks she needs to go to the house. One day she was insistent that she needed to go into a room that wasn't her room. Confusion. She kind of doesn't know her surroundings. I believe that she had a tab alarm, but I think it was discontinued. HH. On 07/25/14 at 4:43 pm during interview with R #8, when asked if staff checks on her every couple hours, she responded No, I'm alone by myself. Once in awhile when they go by, they sneak by. II. Record review of Post-Incident Actions for R #8 revealed: 1. 03/27/14 Narrative of incident: CNA found resident on floor of her bathroom. Resident stated she was trying to use the toilet. Post-incident action: Remind resident to use call bell button and wait for assistance when needing to transfer. Immediate

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	325059	A. BUILDING _____ B. WING _____	07/29/2014

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ESPANOLA VALLEY NURSING AND REHAB	720 HACIENDA STREET ESPANOLA, NM 87532

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 0323 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 7) actions taken: Vital sign taken and assessed for pain and injury. 2. 04/15/14 Narrative of incident: Res was found sitting on floor next to her room in the hallway with the wheelchair at the door. Res stated that she just felt like walking and slid on her bottom. Res was in her socks. Res able to move all extremities, res denies hitting her head. Res denies pain/discomfort. Will continue to monitor. Immediate post-incident action: 72 hour follow up. Encourage to get help. Immediate actions taken: 72 hour follow up. 3. 05/06/14 Narrative of incident: res was found on floor with a blanket spread out on floor in her room. when asked what happened, she stated she sat down to do exercises and stated she did not fall. denies pain. no injuries. Immediate post-incident action: encourage to use cal light. Immediate actions taken: vs (vital signs), assess pain level, assess for injuries. 4. 05/14/14 Narrative of incident: Resident found sitting on floor infront of couch in room. She states she is looking for her mothers things. Resident scooting on floor looking for mothers things. Resident helped up, with minimal assistance. Resident had no complaints of pain with fall or rom (range of motion). family called message left and dr. non emergency line called. 5. 05/17/14 Narrative of incident: res stated she sat on floor and did not fall. no injuries no pain. Immediate post-incident action: call light in place and working order. 6. 05/20/14 Narrative of incident: resident found on floor in bathroom. Resident denies pain. Resident stated that she was trying to get from 'the toilet to the bathroom.' skin assessment done. some redness on left armpit. no bruising or bleeding noted. Immediate Post-incident action: 72 hour follow up. Immediate actions taken: skin assessment, resident transferred to wheelchair. JJ. Record Review of falls/I & A Committee Meeting Minutes revealed: 03/27/14 Found on floor,encouraged to ask for assistance. 04/15/14 Found on floor, pressure alarm. 05/06/14 Found on floor, encouraged to ask for assistance on therapy caseload. 05/14/14 Found on floor, resident placed tab alarm to bed and w/c (wheelchair), on therapy. 05/14/14 Found found on floor, D/c'd pressure alarm, place tab alarm. 05/20/14 Resident found of floor. Resident on bowel and bladder, on therapy caseload. Based on record review, interview and observation the facility failed to ensure that 2 (R #2 and 97) of 4 (R #2, 3, 12 and 97) residents on thickened liquids were free from choking hazards by not providing the appropriate liquid consistency. This deficient practice is likely to result in choking, lung infections and/or death. The findings are: A. On 07/24/14 at 12:21 pm during interview with Restorative Aide (RA) #1 when asked about the consistency of the coffee, she responded, We thicken it to honey. They told me that one packet makes honey. When asked why the coffee packet is labeled 'nectar consistency', she responded, I had asked that question awhile back but that's what they said. B. On 07/26/14 at 12:05 pm during an interview with the Dietary Manager (DM) when asked how do you make honey thickened coffee, he responded, I use 1 pack and then use regular thickener. Shakes are nectar thick. For (name of R #2), I didn't know he was on honey thick liquids. DM confirmed that coffee pack is labeled nectar thick. C. On 07/26/14 at 12:15 pm during interview with RA #2 when asked what fluid consistency R #2 receives, she responded, I believe he is on nectar. When asked what fluid consistency R #97 receives, she responded, I am certain he is on nectar thick. When informed that R #2 and R #97 had an order for [REDACTED]. I guess I would ask the kitchen. D. On 07/26/14 at 12:50 pm during interview with the DM, when asked if restorative is provided with thickeners, he responded, No, If they knew they should come ask for it. When asked who thickens the liquids, he responded, My staff or I would do it. When asked how do you thicken coffee to honey, he responded, With packets (coffee packets). I do not have honey consistency coffee in packets. They have never told me they need honey thick coffee. DM confirmed that he had not been providing resident R #2 and R #97 honey thickened co
F 0329 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**1) Make sure that each resident's drug regimen is free from unnecessary drugs; 2) Each resident's entire drug/medication is managed and monitored to achieve highest well being.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to adequately monitor 1 (R #72) of 5 (R #3, 59, 69, 72, 84) residents reviewed for unnecessary medications. R #72 is taking [MEDICATION NAME], an antipsychotic medication, and the facility is not conducting quarterly assessments. If the facility does not conduct quarterly assessments, the facility is unable to determine whether or not there is a continued need for the medication. This deficient practice is likely to cause the resident to continue to receive the medication unnecessarily, which could result in the resident experiencing side effects. The findings are: A. Record review for R #72 revealed the following: 1. July 2014 physician's orders [REDACTED]. 2. Care plan dated 12/19/13 noted Risk for complication r/t (related to) [MEDICAL CONDITION] meds (medications) (Name of R #72) is prescribed a routine & PRN (as needed) antispychotic; IDT (Interdisciplinary Team) review of effectiveness of medication regimen at least quarterly and PRN. B. On 07/28/14 at 2:00 pm, during interview, the Minimum Data Set (MDS) Coordinator confirmed that they are not conducting quarterly assessments for [MEDICAL CONDITION] medications. C. On 07/29/14 at 2:42 pm, during interview, the Director of Nursing confirmed that they are not conducting quarterly assessments.
F 0332 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Keep the rate of medication errors (wrong drug, wrong dose, wrong time) to less than 5%.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and interview, the facility failed to ensure that the medication error rate did not exceed 5% by performing 2 (two) medication errors out of 26 medication pass opportunities, resulting in a medication error rate of 7.6%. The medication errors occurred for 2 (R #13 & 59) of 6 (4, 7, 13, 22, 59 & 83) residents reviewed during medication pass. On 07/23/14, R #13 failed to receive 30 mg of the ordered pain medication [MEDICATION NAME] sulfate extended release. On 07/25/14, R #59 was dispensed 80 mg of the blood pressure lowering medication [MEDICATION NAME] from R #11's medication supply. If residents do not receive their scheduled pain medications they are likely to experience pain. The deficient practice of dispensing medication to a resident which was not specified for that resident is likely to result in resident's over/under dosing (receiving too much/not receiving enough) of medication and being charged for medication that they did not receive. The findings are. A. On 07/24/14 at 11:17 am during an interview with the Director of Nursing (DON), she confirmed that when staff do not administer a medication the missed dose should be circled in the Medication Administration Record [REDACTED]. B. On 07/24/14 at 4:01 pm during an interview with Licensed Practical Nurse (LPN) #1, she confirmed that staff have a window of an hour before and and hour after to administer medications. LPN #1 confirmed that medications ordered to be administered at 6:00 am, are expected to be administered between 5:00 am and 7:00 am. C. On 07/26/14 at 1:02 pm during an interview with the Assistant Director of Nursing (ADON), she confirmed that nursing staff have an hour before and after a medication is ordered to be administered in which to administer medications. Findings for R #13 D. Record review of the physician's orders [REDACTED]. E. Record review of the MAR indicated [REDACTED]. The MAR indicated [REDACTED]. F. Record review of the Controlled Drug Record dated 07/22/14 to 07/23/14 revealed that the last dispensed dosage of [MEDICATION NAME] sulfate extended release 30 mg was on 07/22/14 at 10:00 pm. G. On 07/23/14 at 7:20 am during an interview with R #13 he confirmed that he did not receive a morning dose of [MEDICATION NAME] sulfate extended release 30 mg. H. On 07/23/14 at 7:25 am during an interview with Licensed Practical Nurse (LPN) #1 he confirmed that the 6:00 am dosage of the [MEDICATION NAME] sulfate extended release 30 mg should have been administered by the night staff. LPN #2 confirmed that the 6:00 am dosage of the [MEDICATION NAME] sulfate on the MAR indicated [REDACTED]. I. Record review of the MAR indicated [REDACTED]. Findings for R #59 J. On 07/25/14 at 9:20 am during an interview with Registered Nurse (RN) #1 she confirmed that nursing staff are not to dispense one residents medications from another resident's medication supply. K. On 07/25/14 at 9:48 am RN #1 was observed to prepare the blood pressure medication [MEDICATION NAME] 80 milligrams (mg) for R #59. RN was observed to dispense the medication from a medication pack labeled for R #11. During an interview with RN she confirmed that she dispensed the medication from R #11's medication supply.
F 0333 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Make sure that residents are safe from serious medication errors.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure no significant medication errors occurred for 1 (R #13) of 6 (#4,#7, #13, #22, #59 & #83) residents reviewed during medication pass by failing to administer the ordered pain relieving medication, [MEDICATION NAME] sulfate extended release, on 07/23/14 at 6:00 am. If residents who have pain are not administered pain relieving medications as ordered by the physician they can experience increased pain and discomfort.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	325059	A. BUILDING _____ B. WING _____	07/29/2014

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ESPANOLA VALLEY NURSING AND REHAB	720 HACIENDA STREET ESPANOLA, NM 87532

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 0333 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 8) The findings are: A. On 07/24/14 at 11:17 am during an interview with the Director of Nursing (DON), she confirmed that when staff do not administer a medication the missed dose should be circled in the Medication Administration Record [REDACTED]. B. On 07/24/14 at 4:01 pm during an interview with Licensed Practical Nurse (LPN) #1, she confirmed that staff have a window of an hour before and and hour after to administer medications. LPN #1 confirmed that medications ordered to be administered at 6:00 am, are expected to be administered between 5:00 am and 7:00 am. C. On 07/26/14 at 1:02 pm during an interview with the Assistant Director of Nursing (ADON), she confirmed that nursing staff have an hour before and after a medication is ordered to be administered in which to administer medications. D. Record review of the physician's orders [REDACTED]. E. Record review of the MAR indicated [REDACTED]. The MAR indicated [REDACTED]. F. Record review of the Controlled Drug Record dated 07/22/14 to 07/23/14 revealed that the last dispensed dosage of [MEDICATION NAME] sulfate extended release 30 mg was on 07/22/14 at 10:00 pm. G. On 07/23/14 at 7:20 am during an interview with R #13, he confirmed that he did not receive a morning dose of [MEDICATION NAME] sulfate extended release 30 mg. H. On 07/23/14 at 7:25 am during an interview with Licensed Practical Nurse (LPN) #2, he confirmed that the 6:00 am dosage of the [MEDICATION NAME] sulfate extended release 30 mg should have been administered by the night staff. LPN #2 confirmed that the 6:00 am dosage of the [MEDICATION NAME] sulfate on the MAR indicated [REDACTED]. I. Record review of the MAR indicated [REDACTED].
F 0431 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Maintain drug records and properly mark/label drugs and other similar products according to accepted professional standards.** Based on observation, interview and record review the facility failed to ensure that prescription medications were kept locked and inaccessible to unauthorized personnel by not securing a medication cart after it was finished being used. This deficient practice is likely to result in all 29 residents identified on the list of residents who are independently ambulatory with and without assistance provided by the Director of Nursing (DON) on 07/26/14 as having free access to prescriptions medications. If residents have free access to prescription medications, they can experience medication side effects such as overdose (being administered too much medication) or other medication interactions. The findings are: A. Record review of the facility's Policy and Procedure (P&P) on Storage of Medication dated September 2010 revealed, In order to limit access to prescription medications, only licensed nurses, pharmacy staff and those lawfully authorized to administer medication (such as medication aides) are allowed access to medication carts. Medication rooms, cabinets and medication supplies should remain locked when not in use or attended by persons with authorized access. B. On 07/22/14 at 10:58 am during an interview Registered Nurse (RN) #1, she confirmed that she was finished passing medications to residents in the 500 hall. C. On 07/22/14 at 10:58 am RN #1 was observed to walk away from the medication cart located on the 500 hall, leaving it unlocked. The medication cart was able to be opened by passersby. D. On 07/22/14 at 11:05 am RN #1 was observed to return to the medication cart located on the 500 hall and confirmed that the medication cart was left unlocked.
F 0497 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	**1) Review the work of each nurse aide every year; and 2) give regular in-service training based upon these reviews.** Based on record review and interview, the facility failed to conduct a performance review at least once every 12 months for 6 of 6 nurse aides reviewed. This deficient practice presents a risk that nurse aides will not be proficient in their skills, which could result in inadequate care being provided to all 79 residents in the facility, listed on the Resident Census provided by the Administrator on July 20, 2014. The findings are: A. Record review of the performance reviews for Certified Nurse Aide's (CNA) revealed the following: 1. Certified NUrse Aid (CNA) #7 has a Date of Hire (DOH) of 08/18/98. The last evaluation conducted for this CNA was 09/11/12. 2. CNA #8 has a DOH of 02/18/09. The last evaluation conducted for this CNA was 05/01/12. 3. CNA #9 has a DOH of 01/08/07. The last evaluation conducted for this CNA was 02/23/09. 4. CNA #10 has a DOH of 03/17/08. There was no evaluation in this CNA's file. 5. CNA #11 has a DOH of 06/13/13. There was no evaluation in this CNA's file. 6. CNA #12 has a DOH of 08/18/95. There was no evaluation in this CNA's file. B. On 07/28/14 at 2:23 pm, during interview, the Staff Development Coordinator (SDC)/Human Resources (HR) confirmed that these were the current ones. C. On 07/29/14 at 11:38 am, during interview, the Director of Nursing stated she does not know when evaluations are being done. The Staff Development Coordinator/HR is the one that handles it. D. On 07/26/14 at 1:48 pm, during interview, SDC/HR stated that there are not any evaluations for CNA #12 in the file. She confirmed that the Performance Appraisals for CNA #7, CNA #8 and CNA #9 were overdue. When asked about the Performance Appraisals for CNA #10 and CNA #11, the SDC/HR stated that they did not have any for them because they had not worked in the last year. When asked if they were still employed as CNA's, she stated yes.
F 0514 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Keep accurate, complete and organized clinical records on each resident that meet professional standards** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure that the medical record was accurate for 2 (R #13 & 69) of 10 (R #3, 4, 7, 13, 22, 52, 59, 72, 83 & 84) reviewed for unnecessary medications and during medication pass by not indicating why a medication was not administered on the Medication Administration Record (MAR). If a resident's MAR does not indicate why medications were not administered, staff cannot accurately asses a medications effectiveness. The findings are. Findings for R #13 A. Record review of the physician's orders [REDACTED]. B. Record review of the Medication Administration Record (MAR) dated 07/23/14 revealed the pain medication [MEDICATION NAME] sulfate extended release 30 mg was to be administered at 6:00 am. The MAR did not indicate that the morning dose of medication had been administered and no rational was provided as to why. C. Record review of the Controlled Drug Record dated 07/22/14 to 07/23/14 revealed that the last dispensed dosage of [MEDICATION NAME] sulfate extended release 30 mg was on 07/22/14 at 10:00 pm. D. On 07/23/14 at 7:20 am during an interview with R #13 he confirmed that he did not receive a morning dose of [MEDICATION NAME] sulfate extended release 30 mg. E. On 07/23/14 at 7:25 am during an interview with Licensed Practical Nurse (LPN) #2, he confirmed that the 6:00 am dosage of the [MEDICATION NAME] sulfate extended release 30 mg should have been administered by the night staff. LPN #2 confirmed that the 6:00 am dosage of the [MEDICATION NAME] sulfate on the MAR was not signed off as being administered on 07/23/14. F. Record review of the MAR dated 07/23/14 and viewed at 7:24 am revealed no documentation that indicated why the 6:00 am dosage of the [MEDICATION NAME] sulfate extended release 30 mg not administered. Findings for R #69 G. On 07/24/14 at 11:17 am, during an interview with the Director of Nursing (DON), she confirmed that when staff do not administer a medication the missed dose should be circled in the MAR and a rational given as to why the medication was not administered. The DON confirmed to that R #69's MAR did not indicate that the resident received 1000 mcg of the medication Vitamin B12 in December 2013 or 150 mcg or [MEDICATION NAME] was administered on 02/14/14. DON confirmed that both instances on the MAR should have indicated why the medication was not documented as being administered. H. Record review of physician's orders [REDACTED].#69 1000 mcg (micrograms) of the medication Vitamin B12 (a type if vitamin B). I. Record review of the MAR dated 12/01/13 to 12/31/13 revealed no indication that 1000 mcg of Vitamin B12 was administered, no rational was documented as to why the medication was not signed off as being administered. J. Record review of physician's orders [REDACTED].#69 150 mcg (micrograms) of the medication [MEDICATION NAME] (a medication for underactive [MEDICAL CONDITION]) daily. K. Record review of the MAR dated 02/01/14 to 02/28/14 revealed no indication that [MEDICATION NAME] 150 mcg was administered on 02/14/14. No rational was documented as to why the medication was not signed off as being administered. Additional Findings L. On 07/24/14 at 11:17 am during an interview with the DON, she confirmed that when staff do not administer a medication the missed dose should be circled in the MAR and rational given as to why the medication was not administered. M. On 07/24/14 at 4:01 pm during an interview with LPN #1, she confirmed that staff have a window of an hour before and and hour after to administer medications. LPN #1 confirmed that medications ordered to be administered at 6:00 am, are expected to be administered between 5:00 am and 7:00 am. N. On 07/26/14 at 1:02 pm during an interview with the ADON, she confirmed that nursing staff have an hour before and after a medication is ordered to be administered in which to administer medications.