STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	325030	A. BUILDING _____ B. WING _____	11/20/2015

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
SANTA FE CARE CENTER	635 HARKLE ROAD SANTA FE, NM 87505

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 0157 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	**Immediately tell the resident, the resident's doctor and a family member of the resident of situations (injury/decline/room, etc.) that affect the resident.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based upon record review and interview during a complaint investigation related to falls, it was discovered that R #1 experienced a fall on [DATE] and sustained a fractured rib. Over the next 4 days, the facility failed to appropriately monitor the resident's status and provide needed interventions when the R #1's mental status and vital signs began to decline to the point of needing emergent medical interventions. The delay in treatment likely resulted in the resident's death. Following the incident, the facility did not identify root cause or contributions to the resident's decline and did not provide feedback and education to nursing staff to prevent any similar situations. These deficient practices resulted in an Immediate Jeopardy (IJ) being identified at the facility on [DATE] at 4:45pm.The facility Administrator was notified at this time. The facility took corrective action by providing an acceptable Plan of Removal on [DATE] at 12:00 pm. Based on the plan, interventions included: 1. Staff working on this day were provided the information and topics included in the Plan of Removal 2. Changes in resident condition will be reported on the 24-hour report tool, discussed in IDT meetings, and interventions will occur as warranted. 3. The MD will be notified of any changes in condition for additional orders, diagnostic testing, follow-up and assessment/evaluation. Nurses will use their judgment involving emergency transport to acute care, even without an MD order, unless otherwise stated in the residents advance directive. The MD and responsible party will be notified following transport. 4. All oncoming staff will be inserviced on the center Stop and Watch (Early Intervention) principles related to informing the floor nurse of observed changes in the resident's condition. This will be included in New Hire orientation. 5. All oncoming nurses will be inserviced on change in condition agenda including: a. Documenting change in condition describing the change. b. Stop and Watch will be used to identify early warning signs of changes in condition. 6. Vital signs for all in-house residents have been taken and compared to baseline vitals and any negative findings will be reported to the MD immediately. Based on the Plan of Removal, the IJ was lifted. This resulted in the scope and severity being reduced from a J to Level 2, Scope D. Based on record review and interview, the facility failed to consult with the physician when 1 (R #1) of 4 (R #1, 2, 3 and 4) residents reviewed for falls, continued to have a decrease in blood pressure and oxygenation (amount of oxygen in a person's blood) and increase lethargy (drowsy) and change in mental status on [DATE] after interventions ([MEDICATION NAME] (medication used to treat the side effects of opioids, opioid overdose, and septic shock)) were implemented. By not notifying the physician of a lack of improvement after an intervention was provided, this deficient practice likely resulted in a delay in treatment and R #1's death. The findings are: A. Record review of Departmental Nursing Notes dated [DATE] revealed, At approximately 1250 pm, (name of staff member #1) in activities called my attention to a fall in room [ROOM NUMBER]A, on arriving I found (name of R #1) on the floor slanted towards the right side. I got him up to the wheelchair and asked him what happened. He said he was trying to put off the overhead light and fell because he couldn't support himself with his right hand in a splint. Resident refused hitting his head and reported pain in his lower back. Resident was otherwise stable and vital signs was ,[DATE] (blood pressure), T (temperature) 97.5 (Fahrenheit), P (pulse) 80, O2 (oxygen saturation in blood) 93%, R (respirations) 19. Pain was rated at ,[DATE], and 650 mg (milligrams) of Tylenol was given and one hour later was ,[DATE] (pain rating) .resident later opted for X-ray because of unrelieved pain . B. Record review of Radiology Interpretation dated [DATE] revealed that R #1 had a fractured rib. C. Record review of physician progress notes [REDACTED].#1 dated [DATE] revealed, Vital signs are stable. He is alert, cooperative, with clear speech .He is in no acute distress .Reparations (sic) (respirations) are normal, unlabored .no abnormal breath sounds are auscultated (heard). No pleural friction rubs (sounds when there is fluid in the lungs) or wheezing present . D. Record review of Departmental Nursing Notes reveled: 1. On [DATE] F/U fall [DATE] resident was complaining of pain to right rib area on [DATE] was examined by in house PA (PA #1) X-ray ordered to right chest 3 View the AP (front and back) view of chest with acute [MEDICAL CONDITION] 10th rib, Results called to MD (medical doctor #1) @ (at) 0625 (6:25 am) who gave no further orders but to keep residents pain in control with PRN (as needed) [MEDICATION NAME] (Opioid pain reliever) or [MEDICATION NAME] (Pain reliever) which was ordered on the previous day by PA (PA #1) . 2. On [DATE] Resident up with PT (physical therapy) today in chair and WC (wheel chair), refused breakfast but had lunch and dinner. Pain right rib cage area well controlled with [MEDICATION NAME] q (every) 6 hrs (hours) scheduled order. Right arm in sling, [MEDICATION NAME] (pain patch) to right shoulder, with positive relief of pain. 3. On [DATE] at 11:41 am Nurses Note: (name of R#1) was very somulent (sic) (drowsy) this morning. He was unable to articulate words. (Name of MD #1) ASSESSED him and decided to take him off routine [MEDICATION NAME] and to give him [MEDICATION NAME]. Vital signs as follows: BP (blood pressure) ,[DATE] P (pulse) 86 R (respirations) 16. O2 sat (oxygen saturation in the blood) to room air was 77% and on o2 at 3 liters it read at 88% at noon his was able to take his medications and swallowed without difficulty. More alert and able to answers yes and no questions. [MEDICATION NAME] ordered from pharmacy. I will give him the [MEDICATION NAME] as soon as it comes in. No congestion noted. His skin is pink warm, dry and intact. Has a sling on his left arm . E. Record review of physician progress notes [REDACTED]. He is sleeping but easily arousable but falls back to sleep when he stopped talking to him .Respiratory: .the breath sounds are diminished at both bases .Plan: .2. Give opiate [MEDICATION NAME] ([MEDICATION NAME]) when necessary moderate to severe pain. 3. [MEDICATION NAME] 0.4 mg (milligram) IM (intramuscular) x 1 dose . F. Record review of Physician Telephone Orders dated [DATE] revealed, 1- Give [MEDICATION NAME] on PRN (as needed) basis only for moderate to severe pain; otherwise, use Tylenol as ordered. 2- Vital signs TID (three times a day) x 1 wk then daily QAM (every morning) 4- Encourage po (by mouth) fluid intake when he's back to his pre-lethargic (pre-drowsy) state G. Record review of Departmental Notes dated [DATE] at 6:36 pm revealed, Nurses Note: I (RN #2) gave him [MEDICATION NAME] 0.4 mg IM (Intramuscular) on his left thigh at 11:30 and he was more alert a few min (minutes) after. He had two emesis

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

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F 0157

Level of harm - Immediate jeopardy

Residents Affected - Few

(continued... from page 1)

(vomiting) of yellow colar (sic) emesis and I gave him [MEDICATION NAME] (medication to decrease nausea and vomiting) and the emesis subsided. His O2 sat is still low at 81% to o2 at 5 liters. BP ,[DATE]. P 106. T 97.3. more alert and able to answer questions.

H. Record review of the Medication Administration Record/Treatment Administration Record (MAR/TAR) dated [DATE] to [DATE] revealed vital signs in the following order: Temperature, Blood Pressure, Pulse, Respiration and Oxygen Saturation (in the blood):

1. [DATE]: 97.6 (Fahrenheit temperature), ,[DATE] (Blood Pressure), 60 (Pulse), 20 (Respiration), 95% (Oxygen Saturation) on room air (RA)
2. [DATE]: 97.7, ,[DATE], 72, 20, 92% RA
3. [DATE]: 96.7, ,[DATE], 76, 20, 98% RA
4. [DATE]: 98.6, ,[DATE], 80, 18, 92% RA
5. [DATE]: 98.1, ,[DATE], 83, 18, 92% RA
6. [DATE]: 97.4, ,[DATE], 74, 18, 96% RA
7. [DATE]: 97.3, ,[DATE], 86, 16, 93% RA
8. [DATE]: 97.6, ,[DATE], 86, 16, 87% (with supplemental oxygen)
9. [DATE]: 97.4, ,[DATE], 99, 16, 87% (with supplemental oxygen)

I. Record review of Departmental Notes revealed:

1. On [DATE] at 1:04 pm, Change in Condition: Resident very lethargic since start of my shift at 6AM this morning. Had respiratory depression yesterday due to [MEDICATION NAME] ,[DATE], given [MEDICATION NAME]. Vitals signs improving from yesterdays, but o2 still <90 on %LNC (Liters Nasal Cannula). Hasn't been able to eat today and have difficulty verbalizing needs. Family is worried and wants him to be transferred to the hospital. MD notified and approved transfer. Vitals signs are as follows; 97.4, ,[DATE], 99, 18, o2 87% 5LNC.
2. On [DATE] 8:31 am Discharge summary: Resident was discharged to (name of Hospital (H) #1) on [DATE] per family's request. Resident is anticipated to return.

J. Record review of Admission Notes from H #1 dated [DATE] revealed, HISTORY: This [AGE] year-old male .was admitted to this institution [DATE] for altered mental status, [MEDICAL CONDITION], and hypoxemia. The patient had a history of [REDACTED].

He had been at a skilled nursing facility/rehab facility since that time .On admission to the emergency room , the patient was delirious. Further medical evaluation revealed the patient had a type 2 non-STEMI ([MEDICAL CONDITION]), septic shock, hypercapnic [MEDICAL CONDITION] (arterial oxygen and/or carbon [MEDICATION NAME] levels are not maintained in normal ranges) with acute kidney failure. The patient was taken to critical care unit, where he has remained until today. He was intubated (breathing tube inserted) and given maximal medical support. The patient has now been exubated (breathing tube removed). He is off pressors (blood pressure medication). He is confused but following simple commands and answering simple questions mostly in Spanish. He has profound dysphagia (inability to swallow) and is unable to swallow more than a sip or two of liquid .PLAN: 1. Admit to Inpatient Hospice .

K. Record review of Discharge-Transfer Documentation dated [DATE] at 4:09 pm revealed, Condition on Discharge: expired

L. On [DATE] at 3:25 pm during and interview with MD #1, when asked what happened on [DATE] with R #1, he stated, The best of my recollection, they gave him the [MEDICATION NAME] and he was back to the way he was before he was lethargic, and then the family wanted him to go to the hospital. MD #1 confirmed that he only contacted by the facility when the order for [MEDICATION NAME] was given and when the family requested R#1 to be taken to the emergency room in the afternoon of [DATE].

He confirmed that at no other time was he contacted by the facility for R #1.

M. On [DATE] at 9:45 am during an interview with Family Member (FM) #1, when asked if he could tell me what happened with R #1 on and before [DATE], he stated, I kept in touch calling there (facility). From my understanding he fell and broke some ribs. He requested to go to the hospital, and they said he couldn't go to the hospital because they couldn't do anything for him. His roommate told us that he wanted to go to the hospital. My sister and I were surprised. From day one that he broke his rib, it went downhill from there. His roommate requested that we don't tell anyone what happened because there would be retaliation. I thought they had changed his medication ([MEDICATION NAME]) after they thought it didn't work and he got so drowsy on it. That's what they said they did. When we went to (name of H #1) the cardiologist said that he had a [MEDICAL CONDITION]. When my sister came to see him (On [DATE] in the nursing facility), he was gray and not talking and she immediately ran to the nurses and told them he needs to go to the ER. They said that they were thinking of sending him, but they didn't send him. You think! He wasn't ok! They are nurses, and they should know to send him if he looks like that and he wasn't breathing well. His roommate even thought he should go and they didn't send him. I don't know if the outcome would have been any different, but if they had acted when they should have, it could have been. We can't know that. People go (die) when they have to, but we want to make sure this doesn't happen to someone else. That is all that we want.

N. On [DATE] at 11:40 am during an interview with Registered Nurse (RN) #1 when asked what had happened with R #1 on [DATE],

he stated, I took care of him the week before (the fall) and I saw him different (lethargic after the fall) from when I took care of him. I reported to the doctor that we needed to send him out. They said because he was on pain meds, he was drowsy. We gave him [MEDICARE NAME] and he responded to that and his sats (O2 saturation) improved after that. I guess he continued to get better. His sats were low, but he was doing better. I contacted the family that day ([DATE]) and I let them know what was going on. (Name of RN #2), the next day contacted the family because he was still not the same. With the help of the family, we decided to send him out. RN #1 confirmed that he gave the [MEDICATION NAME] one hour after it was ordered R #1's blood pressure and oxygen saturation improved, but were still lower than normal range (safe levels) for R #1. RN #1 confirmed that R #1 was vomiting in the morning of [DATE]. When asked if he suggested to send the resident to the emergency room , he stated, It wasn't a sense of urgency, but I knew something needed to be done. He confirmed that he considered sending him out that morning, but he needed a doctor's order to do so. He stated, The doctor was there (at the facility on [DATE]), so we couldn't send him out. We do what the doctor orders. When asked if there were any in services or education after the incident occurred, he confirmed that he received no in service or educations.

O. On [DATE] at 11:55 am during interview with LPN #2, he confirmed that he had not received any inservices or education after [DATE]. When asked if he has the authority to call an ambulance if a resident needs, LPN #2 stated Yes, definitely. I can call the ambulance, if it is something I can't take care of here.

P. On [DATE] at 12:04 pm during an interview with Nurse Practitioner #1, when asked if she can explain what the signs and symptoms one may see in someone having a [MEDICAL CONDITION], she stated, You may not see anything. You may see increased

fatigue, changes in normal status, more lethargic, general chest discomfort. Anyone that is with it, they most likely have typical symptoms. Men present with more symptoms, normally. With vital signs, you may see no changes, big changes, tachy (increased heart rate), irregularities in heart rate, blood pressure can go down or up. The most important thing is to learn the residents so you can see those changes. When asked if someone may have nausea and vomiting related to a [MEDICAL CONDITION], she confirmed that they could. When asked if she had a resident presenting with the following vital signs: BP ,[DATE] P 86 R 16 and O2 sat to room air was 77% and on O2 at 3 liters it read at 88% (R #1's vital signs on [DATE]) She stated, I would send them out (to the emergency room). When asked if the resident was given [MEDICATION NAME] and the vital signs improved, but were still out of range, what would she think, she stated, I would say that it improved because of the [MEDICATION NAME]. When asked if the resident presented the same way the next day, what would she do, she stated, I would have sent them out to begin with. I have an emergency medicine background, and I always assume the worst, especially if I know the patient. I question the care here and whether they know what they are doing. If I saw vital signs like this, I would assume the person has a PE (pulmonary embolism (blood clot in the lungs)), or is having an OD (over dose). With an OD, you would see the pulse drop. In this case, it was tachy (increased heart rate), I think that would point to something else.

Q. On [DATE] at 3:45 pm during interview with R #5 (Roommate for R #1), he stated that after the fall, He looked terrible. He was unresponsive a lot. I knew something was wrong but I was told to not get involved. When the ambulance came to pick him up ([DATE]) and they took him away, he had his head down to the bed. I knew he was here to recover from a stroke and that he was doing real well up until the fall. I never really saw that the nurses were doing more for him after the fall. He would moan and groan everytime he moved and at night he would cry out in pain after the fall.

R. On [DATE] at 4:20 pm during interview with the Administrator, he stated that he provided inservices to staff at stand up regarding stop and watch, what to do in an emergency situation, change of condition, and SBAR (Situaltion Background Assessment Reccomendation) {way to communicate from staff to staff). When asked, the Administrator confirmed that he provided these educations to RN #1 and RN #2 (Both nurses denied ever receiving training post [DATE]. See Finding N and T).

S. At [DATE] on 8:35 am during an interview with Corporate Registered Nurse (CRN #1), she stated, I know as a nurse that you

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F 0157 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 2) can make the call if the doctor isn't making the decisions needed. I definitely saw what you all were seeing. She confirmed that she saw the documentation on the incident, and it was not clear why they did not send him to the emergency room sooner. She stated, I see why you called it (the Immediate Jeopardy). As a nurse, you don't need an order to send someone out. T. On [DATE] at 9:32 am during an interview with RN #2, when asked what happened with R #1 from the time he came on shift on [DATE] until the R #1 was sent to the emergency room (ER), he stated, When I came on, I got report that he (R#1) is not feeling ok. So I didn't go physically assess him because he was still in bed. The nurse (Licensed Practical Nurse (LPN) #1) told me that the doctor didn't want to send him out. When I finally got to him, he wasn't looking good from the last time I saw him 3 days ago. I looked at him and contemplating sending him out. He wasn't eating, and couldn't take meds (medications). His family came in about 30 minutes after I saw him. The daughter asked me how he was and what I think. I told her he didn't look good and I think he should go out and she thought he needed to go out. I called the ambulance. I didn't do any nursing care with him that morning. When asked how soon after report he assessed R #1, he confirmed that he did not do an assessment or nursing care on him because he thought he was sleeping. When asked if the LPN #1 had given him a report of what had happened to the resident the day prior, he confirmed that he knew that the resident had fallen, and he was not doing well, but he did not get specifics about what had happened. He stated, What I do know is that the doctor saw him and didn't want to send him out, I didn't investigate further. The nurse (LPN #1) said she thought he should go out (in morning report). When asked if a nurse can call an ambulance without a doctors order, he confirmed that they can if they feel it is emergent. When asked if he received any report that R # 1 should be more closely monitored because of his condition the day prior, he confirmed that he got the residents vital signs once and no one had mentioned frequent monitoring. When asked if the resident's oxygen saturation (oxygen level in the blood) was low when he checked his vitals, he confirmed that his O2 sat was still lower than normal (below 90%) and that the resident was on oxygen. When asked if he received any in services, trainings or education after this incident happened, he confirmed that he did not get any in services or trainings. U. Record review of Nursing Services Policy and Procedure Manual: Making an Emergency Transfer or discharge date d 2001, revised [DATE] revealed Our facility shall make an emergency transfer or discharge when it is in the best interest of the resident.
F 0309 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	**Provide necessary care and services to maintain the highest well being of each resident** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based upon record review and interview during a complaint investigation related to falls, it was discovered that R #1 experienced a fall on [DATE] and sustained a fractured rib. Over the next 4 days, the facility failed to appropriately monitor the resident's status and provide needed interventions when the R #1's mental status and vital signs began to decline to the point of needing emergent medical interventions. The delay in treatment likely resulted in the resident's death. Following the incident, the facility did not identify root cause or contributions to the resident's decline and did not provide feedback and education to nursing staff to prevent any similar situations. These deficient practices resulted in an Immediate Jeopardy (IJ) being identified at the facility on [DATE] at 4:45pm.The facility Administrator was notified at this time. The facility took corrective action by providing an acceptable Plan of Removal on [DATE] at 12:00 pm. Based on the plan, interventions included: 1. Staff working on this day were provided the information and topics included in the Plan of Removal 2. Changes in resident condition will be reported on the 24-hour report tool, discussed in IDT meetings, and interventions will occur as warranted. 3. The MD will be notified of any changes in condition for additional orders, diagnostic testing, follow-up and assessment/evaluation. Nurses will use their judgment involving emergency transport to acute care, even without an MD order, unless otherwise stated in the residents advance directive. The MD and responsible party will be notified following transport. 4. All oncoming staff will be inserviced on the center Stop and Watch (Early Intervention) principles related to informing the floor nurse of observed changes in the resident's condition. This will be included in New Hire orientation. 5. All oncoming nurses will be inserviced on change in condition agenda including: a. Documenting change in condition describing the change. b. Stop and Watch will be used to identify early warning signs of changes in condition. 6. Vital signs for all in-house residents have been taken and compared to baseline vitals and any negative findings will be reported to the MD immediately. Based on the Plan of Removal, the IJ was lifted. This resulted in the scope and severity being reduced from a J to Level 2, Scope D. Based on record review and interview, the facility failed to ensure that 1 (R #1) of 4 (R #1, 2, 3 and 4) residents reviewed for falls received the necessary services to maintain the highest practicable well-being by: 1. Not identifying that R #1's decrease in blood pressure and oxygenation (amount of oxygen in a person's blood) and increase lethargy (drowsy) and change in mental status on [DATE] required emergency medical treatment. 2. Not consulting with the physician on [DATE] after R #1 received [MEDICATION NAME] (medication used to treat the side effects of opioids, opioid overdose, and septic shock). and his blood pressure and oxygenation was below safe levels. By not identifying changes in a residents condition or notifying the physician of a lack of improvement after an intervention was provided it, this deficient practice likely resulted in a delay in treatment and R #1's death. The findings are: A. Record review of Departmental Nursing Notes dated [DATE] revealed, At approximately 1250 pm, (name of staff member #1) in activities called my attention to a fall in room [ROOM NUMBER]A, on arriving I found (name of R #1) on the floor slanted towards the right side. I got him up to the wheelchair and asked him what happened. He said he was trying to put off the overhead light and fell because he couldn't support himself with his right hand in a splint. Resident refused hitting his head and reported pain in his lower back. Resident was otherwise stable and vital signs was ,[DATE] (blood pressure), T (temperature) 97.5 (Fahrenheit), P (pulse) 80, O2 (oxygen saturation in blood) 93%, R (respirations) 19. Pain was rated at ,[DATE], and 650 mg (milligrams) of Tylenol was given and one hour later was ,[DATE] (pain rating) .resident later opted for X-ray because of unrelieved pain . B. Record review of Radiology Interpretation dated [DATE] revealed that R #1 had a fractured rib. C. Record review of physician progress notes [REDACTED].#1 dated [DATE] revealed, Vital signs are stable. He is alert, cooperative, with clear speech .He is in no acute distress .Reparations (sic) (respirations) are normal, unlabored .no abnormal breath sounds are auscultated (heard). No pleural friction rubs (sounds when there is fluid in the lungs) or wheezing present . D. Record review of Departmental Nursing Notes revealed: 1. On [DATE] F/U fall [DATE] resident was complaining of pain to right rib area on [DATE] was examined by in house PA (PA #1) X-ray ordered to right chest 3 View the AP (front and back) view of chest with acute [MEDICAL CONDITION] 10th rib, Results called to MD (medical doctor #1) @ (at) 0625 (6:25 am) who gave no further orders but to keep residents pain in control with PRN (as needed) [MEDICATION NAME] (Opioid pain reliever) or [MEDICATION NAME] (Pain reliever) which was ordered on the previous day by PA (PA #1) . 2. On [DATE] Resident up with PT (physical therapy) today in chair and WC (wheel chair), refused breakfast but had lunch and dinner. Pain right rib cage area well controlled with [MEDICATION NAME] q (every) 6 hrs (hours) scheduled order. Right arm in sling, [MEDICATION NAME] (pain patch) to right shoulder, with positive relief of pain. 3. On [DATE] at 11:41 am Nurses Note: (name of R#1) was very somulent (sic) (drowsy) this morning. He was unable to articulate words. (Name of MD #1) ASSESSED him and decided to take him off routine [MEDICATION NAME] and to give him [MEDICATION NAME]. Vital signs as follows: BP (blood pressure) ,[DATE] P (pulse) 86 R (respirations) 16. O2 sat (oxygen saturation in the blood) to room air was 77% and on o2 at 3 liters it read at 88% at noon his was able to take his medications and swallowed without difficulty. More alert and able to answers yes and no questions. [MEDICATION NAME] ordered from pharmacy. I will give him the [MEDICATION NAME] as soon as it comes in. No congestion noted. His skin is pink warm, dry and intact. Has a sling on his left arm .

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Level of harm - Immediate jeopardy

Residents Affected - Few

(continued... from page 3)

E. Record review of physician progress notes [REDACTED]. He is sleeping but easily arousable but falls back to sleep when he stopped talking to him .Respiratory: .the breath sounds are diminished at both bases .Plan: .2. Give opiate [MEDICATION NAME] ([MEDICATION NAME]) when necessary moderate to severe pain. 3. [MEDICATION NAME] 0.4 mg (milligram) IM (intramuscular) x 1 dose .

F. Record review of Physician Telephone Orders dated [DATE] revealed, 1- Give [MEDICATION NAME] on PRN (as needed) basis only for moderate to severe pain; otherwise, use Tylenol as ordered. 2- Vital signs TID (three times a day) x 1 wk then daily QAM (every morning) 4- Encourage po (by mouth) fluid intake when he's back to his pre-lethargic (pre-drowsy) state

G. Record review of Departmental Notes dated [DATE] at 6:36 pm revealed, Nurses Note: I (RN #2) gave him [MEDICATION NAME]
0.4 mg IM (Intramuscular) on his left thigh at 11:30 and he was more alert a few min (minutes) after. He had two emesis (vomiting) of yellow colar (sic) emesis and I gave him [MEDICATION NAME] (medication to decrease nausea and vomiting) and the emesis subsided. His O2 sat is still low at 81% to o2 at 5 liters. BP ,[DATE]. P 106. T 97.3. more alert and able to answer questions.

H. Record review of the Medication Administration Record/Treatment Administration Record (MAR/TAR) dated [DATE] to [DATE] revealed vital signs in the following order: Temperature, Blood Pressure, Pulse, Respiration and Oxygen Saturation (in the blood):

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7. [DATE]: 97.3, ,[DATE], 86, 16, 93% RA
8. [DATE]: 97.6, ,[DATE], 86, 16, 87% (with supplemental oxygen)
9. [DATE]: 97.4, ,[DATE], 99, 16, 87% (with supplemental oxygen)

I. Record review of Departmental Notes revealed:

1. On [DATE] at 1:04 pm, Change in Condition: Resident very lethargic since start of my shift at 6AM this morning. Had respiratory depression yesterday due to [MEDICATION NAME] ,[DATE], given [MEDICATION NAME]. Vitals signs improving from yesterdays, but o2 still <90 on %LNC (Liters Nasal Cannula). Hasn't been able to eat today and have difficulty verbalizing needs. Family is worried and wants him to be transferred to the hospital. MD notified and approved transfer. Vitals signs are as follows; 97.4, ,[DATE], 99, 18, o2 87% 5LNC.
2. On [DATE] 8:31 am Discharge summary: Resident was discharged to (name of Hospital (H) #1) on [DATE] per family's request. Resident is anticipated to return.

J. Record review of Admission Notes from H #1 dated [DATE] revealed, HISTORY: This [AGE] year-old male .was admitted to this institution [DATE] for altered mental status, [MEDICAL CONDITION], and hypoxemia. The patient had a history of [REDACTED].
He had been at a skilled nursing facility/rehab facility since that time .On admission to the emergency room , the patient was delirious. Further medical evaluation revealed the patient had a type 2 non-STEMI ([MEDICAL CONDITION]), septic shock, hypercapnic [MEDICAL CONDITION] (arterial oxygen and/or carbon [MEDICATION NAME] levels are not maintained in normal ranges) with acute kidney failure. The patient was taken to critical care unit, where he has remained until today. He was intubated (breathing tube inserted) and given maximal medical support. The patient has now been exubated (breathing tube removed). He is off pressors (blood pressure medication). He is confused but following simple commands and answering simple questions mostly in Spanish. He has profound dysphagia (inability to swallow) and is unable to swallow more than a sip or two of liquid .PLAN: 1. Admit to Inpatient Hospice .

K. Record review of Discharge-Transfer Documentation dated [DATE] at 4:09 pm revealed, Condition on Discharge: expired

L. On [DATE] at 3:25 pm during and interview with MD #1, when asked what happened on [DATE] with R #1, he stated, The best of my recollection, they gave him the [MEDICATION NAME] and he was back to the way he was before he was lethargic, and then the family wanted him to go to the hospital. MD #1 confirmed that he only contacted by the facility when the order for [MEDICATION NAME] was given and when the family requested R#1 to be taken to the emergency room in the afternoon of [DATE].
He confirmed that at no other time was he contacted by the facility for R #1.

M. On [DATE] at 9:45 am during an interview with Family Member (FM) #1, when asked if he could tell me what happened with R #1 on and before [DATE], he stated, I kept in touch calling there (facility). From my understanding he fell and broke some ribs. He requested to go to the hospital, and they said he couldn't go to the hospital because they couldn't do anything for him. His roommate told us that he wanted to go to the hospital. My sister and I were surprised. From day one that he broke his rib, it went downhill from there. His roommate requested that we don't tell anyone what happened because there would be retaliation. I thought they had changed his medication ([MEDICATION NAME]) after they thought it didn't work and he got so drowsy on it. That's what they said they did. When we went to (name of H #1) the cardiologist said that he had a [MEDICAL CONDITION]. When my sister came to see him (On [DATE] in the nursing facility), he was gray and not talking and she immediately ran to the nurses and told them he needs to go to the ER. They said that they were thinking of sending him, but they didn't send him. You think! He wasn't ok! They are nurses, and they should know to send him if he looks like that and he wasn't breathing well. His roommate even thought he should go and they didn't send him. I don't know if the outcome would have been any different, but if they had acted when they should have, it could have been. We can't know that. People go (die) when they have to, but we want to make sure this doesn't happen to someone else. That is all that we want.

N. On [DATE] at 11:40 am during an interview with Registered Nurse (RN) #1 when asked what had happened with R #1 on [DATE],
he stated, I took care of him the week before (the fall) and I saw him different (lethargic after the fall) from when I took care of him. I reported to the doctor that we needed to send him out. They said because he was on pain meds, he was drowsy. We gave him [MEDICATION NAME] and he responded to that and his sats (O2 saturation) improved after that. I guess he continued to get better. His sats were low, but he was doing better. I contacted the family that day ([DATE]) and I let them know what was going on. (Name of RN #2), the next day contacted the family because he was still not the same. With the help of the family, we decided to send him out. RN #1 confirmed that he gave the [MEDICATION NAME] one hour after it was ordered R #1's blood pressure and oxygen saturation improved, but were still lower than normal range (safe levels) for R #1. RN #1 confirmed that R #1 was vomiting in the morning of [DATE]. When asked if he suggested to send the resident to the emergency room , he stated, It wasn't a sense of urgency, but I knew something needed to be done. He confirmed that he considered sending him out that morning, but he needed a doctor's order to do so. He stated, The doctor was there (at the facility on [DATE]), so we couldn't send him out. We do what the doctor orders. When asked if there were any in services or education after the incident occurred, he confirmed that he received no in service or educations.

O. On [DATE] at 11:55 am during interview with LPN #2, he confirmed that he had not received any inservices or education after [DATE]. When asked if he has the authority to call an ambulance if a resident needs, LPN #2 stated Yes, definitely. I can call the ambulance, if it is something I can't take care of here.

P. On [DATE] at 12:04 pm during an interview with Nurse Practitioner #1, when asked if she can explain what the signs and symptoms one may see in someone having a [MEDICAL CONDITION], she stated, You may not see anything. You may see increased fatigue, changes in normal status, more lethargic, general chest discomfort. Anyone that is with it, they most likely have typical symptoms. Men present with more symptoms, normally. With vital signs, you may see no changes, big changes, tachy (increased heart rate), irregularities in heart rate, blood pressure can go down or up. The most important thing is to learn the residents so you can see those changes. When asked if someone may have nausea and vomiting related to a [MEDICAL CONDITION], she confirmed that they could. When asked if she had a resident presenting with the following vital signs: BP ,[DATE] P 86 R 16 and O2 sat to room air was 77% and on O2 at 3 liters it read at 88% (R #1's vital signs on [DATE]) She stated, I would send them out (to the emergency room). When asked if the resident was given [MEDICATION NAME] and the vital signs improved, but were still out of range, what would she think, she stated, I would say that it improved because of the [MEDICATION NAME]. When asked if the resident presented the same way the next day, what would she do, she stated, I would have sent them out to begin with. I have an emergency medicine background, and I always assume the worst, especially if I know the patient. I question the care here and whether they know what they are doing. If I saw vital signs like this, I would assume the person has a PE (pulmonary embolism (blood clot in the lungs)), or is having an OD (over dose). With an OD, you would see the pulse drop. In this case, it was tachy (increased heart rate), I think that would point to something else.

Q. On [DATE] at 3:45 pm during interview with R #5 (Roommate for R #1), he stated that after the fall, He looked terrible.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	325030	A. BUILDING _____ B. WING _____	11/20/2015

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
SANTA FE CARE CENTER	635 HARKLE ROAD SANTA FE, NM 87505

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 0309 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 4) He was unresponsive a lot. I knew something was wrong but I was told to not get involved. When the ambulance came to pick him up ([DATE]) and they took him away, he had his head down to the bed. I knew he was here to recover from a stroke and that he was doing real well up until the fall. I never really saw that the nurses were doing more for him after the fall. He would moan and groan everytime he moved and at night he would cry out in pain after the fall. R. On [DATE] at 4:20 pm during interview with the Administrator, he stated that he provided inservices to staff at stand up regarding stop and watch, what to do in an emergency situation, change of condition, and SBAR (Situaltion Background Assessment Reccomendation) {way to communicate from staff to staff). When asked, the Administrator confirmed that he provided these educations to RN #1 and RN #2 (Both nurses denied ever receiving training post [DATE]. See Finding N and T). S. At [DATE] on 8:35 am during an interview with Corporate Registered Nurse (CRN #1), she stated, I know as a nurse that you can make the call if the doctor isn't making the decisions needed. I definitely saw what you all were seeing. She confirmed that she saw the documentation on the incident, and it was not clear why they did not send him to the emergency room sooner. She stated, I see why you called it (the Immediate Jeopardy). As a nurse, you don't need an order to send someone out. T. On [DATE] at 9:32 am during an interview with RN #2, when asked what happened with R #1 from the time he came on shift on [DATE] until the R #1 was sent to the emergency room (ER), he stated, When I came on, I got report that he (R#1) is not feeling ok. So I didn't go physically assess him because he was still in bed. The nurse (Licensed Practical Nurse (LPN) #1) told me that the doctor didn't want to send him out. When I finally got to him, he wasn't looking good from the last time I saw him 3 days ago. I looked at him and contemplating sending him out. He wasn't eating, and couldn't take meds (medications). His family came in about 30 minutes after I saw him. The daughter asked me how he was and what I think. I told her he didn't look good and I think he should go out and she thought he needed to go out. I called the ambulance. I didn't do any nursing care with him that morning. When asked how soon after report he assessed R #1, he confirmed that he did not do an assessment or nursing care on him because he thought he was sleeping. When asked if the LPN #1 had given him a report of what had happened to the resident the day prior, he confirmed that he knew that the resident had fallen, and he was not doing well, but he did not get specifics about what had happened. He stated, What I do know is that the doctor saw him and didn't want to send him out, I didn't investigate further. The nurse (LPN #1) said she thought he should go out (in morning report). When asked if a nurse can call an ambulance without a doctors order, he confirmed that they can if they feel it is emergent. When asked if he received any report that R # 1 should be more closely monitored because of his condition the day prior, he confirmed that he got the residents vital signs once and no one had mentioned frequent monitoring. When asked if the resident's oxygen saturation (oxygen level in the blood) was low when he checked his vitals, he confirmed that his O2 sat was still lower than normal (below 90%) and that the resident was on oxygen. When asked if he received any in services, trainings or education after this incident happened, he confirmed that he did not get any in services or trainings. U. Record review of Nursing Services Policy and Procedure Manual: Making an Emergency Transfer or discharge date d 2001, revised [DATE] revealed Our facility shall make an emergency transfer or discharge when it is in the best interest of the resident.
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 record review and interview, the facility failed to maintain accurate clinical records for 1 (R#1) of 4 (R#1, 2, 3 and 4) reviewed for falls by not accurately charting late entries. If staff are not accurately identifying late entries in the medical record, other staff or chart reviewers may be unable to determine when treatment, interventions and resident's status assessment occurred, which could likely result in a delay in interventions/treatment or excess interventions/treatments. The findings are: A. Record review of the Policy and procedure for Charting Errors and/or Omissions dated 2001 revealed Late entries in the medical record shall be dated at the time of entry and noted as a 'late entry.' B. Record review of Departmental Notes dated 10/23/15 at 6:36 pm revealed, Nurses Note: I (Registered Nurse #2) gave him [MEDICATION NAME] (medication used to treat the side effects of opioids, opioid overdose, and septic shock) 0.4 mg IM (Intramuscular) on his left thigh at 11:30 and he was more alert a few min (minutes) after. He had two emesis (vomiting) of yellow colar (sic) emesis and I gave him [MEDICATION NAME] (medication to decrease nausea and vomiting) and the emesis subsided. His O2 (oxygen) sat (saturation) (in blood) is still low at 81% to o2 at 5 liters. BP (blood pressure) 76/47. P (pulse) 106. T (tempurature) 97.3. more alert and able to answer questions. C. On 11/18/15 at 9:32 am during an interview withy RN #2, he confirmed that the note for 10/23/15 at 6:36 pm that stated, I gave him [MEDICATION NAME] 0.4 mg IM (Intramuscular) on his left thigh at 11:30 and he was more alert a few minutes after. He had two emesis of yellow colar (sic) emesis and I gave him [MEDICATION NAME] and the emesis subsided. was a note from 11:30 am. The note was not identitfied as a late entry.