STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER **325060**	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED **01/13/2016**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
PALOMA BLANCA HEALTH AND REHABILITATION	**1509 UNIVERSITY BOULEVARD NE ALBUQUERQUE, NM 87102**

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 0314 **Level of harm -** Actual harm **Residents Affected -** Few	**Give residents proper treatment to prevent new bed (pressure) sores or heal existing bed sores.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to identify and/or prevent the development of pressure ulcers for 1 (R #1) of 3 (R #'s 1, 2, and 3) residents reviewed for pressure ulcers. This deficient practice likely resulted in R #1 developing pressure ulcers to the coccyx area, left heel and top of right foot that was left untreated. The findings are: A. Record review of R #1's face sheet revealed, R #1 was admitted on [DATE] with bacteremia (a bacterial infection in the blood), diabetes (DM), dementia with behavioral disturbances, abnormal posture -rigid extremities (both arms and legs), dysphagia (difficulty swallowing) and paralysis agitans ([MEDICAL CONDITION]). B. Record review of R #1's outside service provider Nurse Practitioner's (NP) progress notes dated 11/02/15 revealed, nursing staff reported no acute concerns. Skin was noted as, No visible wounds noted on superficial exam. CDI (cool, dry and intact) and No skin discoloration noted. C. Record review of the facility physician progress notes [REDACTED].#1 was negative (meaning no issues) and indicated nursing reported no new issues. D. Record review of R #1's outside service provider NP's progress notes dated 12/08/15, revealed no documented nursing concerns, no development of any wound or wounds or any documentation indicating a skin assessment was performed on R #1 during this visit. E. Record review of the Weekly Skin Integrity Review reports from 10/23/15 to 12/05/15, revealed; 1. R #1 developed what was described as a, 'Coccyx scrape' on 10/23/15. 2. Documentation from 11/27/15 and 12/05/15 revealed R #1's skin to be intact with no wounds or open areas identified. F. Record review of the facilities wound log book revealed no documentation indicating R #1 had any current wounds or was receiving any treatments for any developing wound. G. Record review of the facility Interdisciplinary Progress (IDT) notes dated 12/10/15 wound meeting notes documented a Stage III (three - a pressure wound that extends into the tissue beneath the skin, forming a small crater) wound to R #1's right hip, first discovered on 12/06/15 per this note. H. Record review of the facility Daily Skilled Nurse's notes dated 11/20/15 to 12/10/15, revealed no documentation that would indicate R #1 had a Stage III pressure wound to his right hip. I. Record review of R #1's physician orders [REDACTED]. J. Record review of the hospital admission record for R #1 dated 12/09/15, revealed R #1 was transferred to the hospital emergency room due to decline in health status. Hospital history and physical (H&P) stated R #1 was noted to have [DIAGNOSES REDACTED] (redness) of the right heel and the left heel was reddened, purple in color with ecchymosis (a discoloration of the skin resulting from bleeding underneath, typically caused by bruising) stage I pressure ulcer. R #1 was also noted to have a sacral decubitus with an area of central necrosis (dead black skin tissue) the size of a Golf ball and stage II pressure ulcer surrounding the area. K. Record review of the hospital Wound Consult note dated 12/10/15, confirmed R #1 was admitted to the hospital with [REDACTED]. Wound assessment indicated the pressure wound to the sacral/coccyx area measured 5 centimeters (cm's) by 6 cm's, the left heel measured 3.5 cm's by 4.0cm's. Also noted was a third wound located on the top of the right foot with necrotic tissue measuring 0.5cm's by 0.5cm's. L. On 01/13/16 at 3:04 pm, during interview the Director of Nursing (DON) stated there was an order to treat a 'Shear' wound on R #1's buttock but that had resolved months ago. The nurses perform daily skin checks. They (nurses) should be looking at everything. When questioned about a 'sacral scrape' documented on 11/13/15, the DON stated she did not know about this wound and that R#1 had developed a shearing wound (friction from sliding on bed linen) but that had resolved. Then the DON confirmed the Weekly Skin Integrity Review reports from 11/27/15 and 12/05/15 indicating R #1's skin to be intact with no wounds or open areas identified. When presented with a copy of the hospital admission Wound Consult note for R #1 dated 12/10/15, the DON stated, she (meaning a staff nurses) didn't mark it on there?, there's nothing there and you would think it would show an opening or something. The DON then stated, if a resident is bed or chair bound she would expect that resident to be turned frequently and have heels floated (elevated on a cushion or use of cushioned boots) to prevent pressure wounds.
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 ensure that the resident's medical record reflected care provided for 2 (R #s 2 and 3) of 3 (R #s 1, 2, and 3) residents reviewed for pressure ulcers. This deficient practice has the potential to cause resident harm by not ensuring that resident care is being provided as ordered. The findings are: Findings for R #2: A. Record review of the Face Sheet dated 12/20/15, indicated R #2 was admitted to the facility on [DATE] with a medical [DIAGNOSES REDACTED]. B. Record review of TAR dated 01/01/16 to 01/31/16, indicated the following treatments: 1. Cleanse wound to peri/buttock area with normal saline and apply small amount of med-honey ointment to wound bed and cover with foam dressing every day and as needed if soiled. There was no documentation to show that treatment had been done as ordered. 2. SSD (Silver [MEDICATION NAME] Cream is a topical antibiotic used to treat or prevent infections) 1% cream, apply topically to affected areas every 3 days for wound care. There was no documentation to show that treatment had been done every 3 days as ordered. 3. R (right) shin care-NS (normal saline), TAO (triple antibiotic ointment), cover with Island drsg (dressing) q'd (every day) and PRN (as needed). There was no documentation to show that treatment had been done on 01/04/16, 01/06/16 to 01/08/16, and 01/12/16. 4. Wound care to R big toe and R 2nd toe: wound cleanser, TAO, Island drsg qd. The documentation shows treatments were not done from 01/03/16 to 01/07/16 and 01/12/16 as ordered. C. Record review of Physician order [REDACTED].

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
PALOMA BLANCA HEALTH AND REHABILITATION	**1509 UNIVERSITY BOULEVARD NE ALBUQUERQUE, NM 87102**

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F 0514 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) 1. On 12/03/15, wound care to R shin- NS, TAO, cover with island drsg QD and PRN. 2. On 12/3/15, change wound care orders to buttock/coccyx: NS, apply sm (small) amt (amount) of med-honey ointment to wound bed cover with foam drsg QD and PRN if soiled. 3. On 12/10/15, wound care to R big toe (inner)-wound cleanser, TAO and Island drsg QD. Wound care to R 2nd toe (inner)-wound cleanser, TAO, and Island drsg QD. D. Record review of the Pressure Ulcer Record dated 01/07/16, indicated R #2 has three pressure ulcers. Pressure ulcer to R leg, unstageable (wound has thick dry black necrotic tissue, stage of wound is not clear), Length (L) is 11 cm (centimeters), Width (W) is 5.2 cm, and wound is black. Ulcer to Coccyx, Stage II (the skin breaks open, wears away, or forms an ulcer, which is usually tender and painful), L is 3.0 cm, W is 2.0 cm, and Depth is 0.1 cm. Ulcer to Left Buttock, Stage I (skin appears reddened, there are no open wounds), L is 2 cm, W is 2 cm. The documentation shows only one note with measurements, stages, and description for R #2's three wounds. Further review of the documentation does not show any other measurements or descriptions of R #2's wounds. E. Record review of Impaired Skin Integrity Care Plan dated 12/20/15, revealed problems to Coccyx-pressure, R leg and L buttocks, R LE (lower extremity)-venous/diabetic. Interventions include: recorded on the Non-Decubitis skin condition record, document weekly; length x (times) width x depth, odor, progress, lack of progress, and current treatment, review at weekly skin meeting, consider supplements, obtain labs, follow product list for appropriate treatment option per MD (medical doctor) and hospice, dressings to be applied as ordered, dressing changes as ordered per MD. F. On 01/13/16 at 11:08 am, during interview the Director of Nursing (DON), stated that she spoke with the hospice nurse and she (hospice nurse) stated she did the measurements with the facility wound nurse, but she (hospice nurse) didn't write them down. The DON confirmed that staff does wound treatment for [REDACTED]. done, unless it's documented in the chart. They haven't been documenting. The DON confirmed staff are not documenting on the TAR that wound care is being done for R #2. G. On 01/13/16 at 11:30 am, during interview with Registered Nurse (RN) #1 regarding wound measurements for R #2's wounds, she stated I don't have measurements. (Name of facility wound nurse), the wound nurse here, we were doing it together and they were keeping measurements on the treatment sheets. I have some fault, I should of have been writing them down. RN #1 confirmed that the facility wound nurse should have been recording wound measurements on the pressure ulcer record. Findings for R #3: H. Record review of the admission record and nurse's notes indicated that R #3 was admitted on [DATE]. R #3 was admitted to the facility with two pressure ulcers. One located on the coccyx and one on the left heel. I. Record review of the Doctor's orders dated 12/17/15 indicates the following wound care orders: 1. Cleanse wound to the left heel, pat dry, apply [MEDICATION NAME] (used to treat minor wounds) to heel corner and gauze wrap with Kerlix (a type of gauze). 2. Cleanse coccyx with wound cleanser, pat dry and apply Sureprep (creates a barrier film on periwound skin) until resolved. J. Record review of the treatment records indicated that from January 01/01/16 - 01/13/15 8 out of 13 opportunities for wound care of the left heel were not done and 11 out of 13 opportunities for wound care of the coccyx were not done. K. On 01/13/16 at 11:20 am, during interview with the DON, she confirmed that there is a lack of documentation in the Treatment Record for R #3's left heel pressure sore and the coccyx pressure sore. L. On 01/13/16 at 1:00 pm, during an interview with R #3, she stated that they (Nurses) don't come in too often to check on the wound to her heel. She stated that it was not daily but she is not sure how often. A Family member of R #3 stated that the wound on her heel isn't getting any better but the one to her coccyx has healed. M. On 01/13/16 at 1:31 pm, during an interview with the DON, she stated that nursing staff was taking care of R #3's pressure sores from the time she arrived at the facility. The DON also stated that there were no Doctor's orders in the medical chart until 12/17/15 and the facility did not receive any orders for wound care when R #3 came to the facility from the hospital.