STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	325113	A. BUILDING _____ B. WING _____	12/22/2016

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
CEDAR RIDGE INN	800 SAGUARO TRAIL FARMINGTON, NM 87401

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 0224 **Level of harm -** Actual harm **Residents Affected -** Few	**Write and use policies that forbid mistreatment, neglect and abuse of residents and theft of residents' property.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure that residents were free from neglect for 1 (R #1) of 5 (R #s ,[DATE]) residents reviewed for falls, wounds and diabetes. This deficient practice likely resulted in delayed identification of R #1's wound and infection and may have contributed to the resident's death. The findings are: A. Record review of R #1's nursing facility medical record indicated an admission date of [DATE] and a discharge date of [DATE]. B. Record review of a Therapy Progress Note indicated the following: 1. [DATE]: Res (resident's) sister was concerned about res skin and appearance to rectal area stating 'it's got blood on it (rectal area).' This PTA (Physical Therapy Assistant) told res sister that we will ask the nurse to come and check it. Explained to res sister that res has had diarrhea for at least 2 days. Nurse from yesterday was also aware. Med (Medication Aide) Aide reports that CNA (Certified Nursing Assistant) communicated that resident has been using the toilet by himself and is not changing his depend (adult brief) when it's soiled and instead, keeps using the soiled one until CNA saw and had res change (it). 2. [DATE]: Pt (patient) stated that he did not want to do therapy today because he is not feeling well and he is in pain. When asked where, he said it (the pain) is when he sits and that he cannot sit for long. Pt supine (laying flat on one's back) in room with sister who stated that he is having very bad pain in his sacral (lower back/buttock) region which is not because of the wound. Pt unable to tolerate sitting. Wound in between gluteal checks sore and inflamed, palpation of area anterior (near the front) to wound, the skin felt solid. Informed nurse that pt had a wound on sacral region in between gluteal cheeks. Nurse stated it was inflammation of the skin due to the constant diarrhea .informed sister and the pt that information was relayed to (Name of Registered Nurse (RN) #1). (Name of RN #1) stated that she wrote a note to the doctor informing him of the wound and solidity of area on bottom. C. Record review of R #1's medical record revealed no documentation to indicate that R #1's physician had been notified of R #1's wound in between the buttocks or the hardened area on the left gluteus (any of three muscles in each buttock that move the thigh) per the therapy progress note dated [DATE]. D. Record review of Nursing Progress Notes indicated the following: 1. [DATE]-[DATE]: Nursing notes did not mention any skin concerns other than slight excoriation (skin abrasion) on the peri (perineal) area (area between genitals and anus). 2. [DATE] at 9:32 am, written by (Name of RN #1): Excoriation on peri area has improved greatly. Resident has hardness noted on R (right) side of glut max (gluteus maximus, buttocks). He is unable to sit comfortably even with cushion. 3. [DATE] at 10:56 am, written by (Name of RN #1): Skin is W/D/I (warm, dry, intact), some excoriation noted in peri area, hardness noted on right glut. Resident reports some pain/discomfort. 4. [DATE] at 8:03 am, written by (Name of RN #2): .This am, resident had redness from his thighs to his knees and the areas were firm and warm to the touch. We turned him to his right side and noted right buttocks was dark brown skin and hard to the touch and warm. The open wound to the lower sacrum and perianal area looks like an ulcer that was about 2 inches long and has a very foul odor and his scrotum is swollen and firm and warm to the touch. His outer thighs were red and firm and warm to the touch. This nurse decided to call (Name of Doctor #1) to get an order to send him to the hospital. E. Record review of the Wound Assessments indicated the following: 1. [DATE]: No open wounds. 2. [DATE]: Wound type: Irritation/excoriation. Wound Location: Coccyx (tail bone area). Date wound identified [DATE]. Present on admission? No. Describe skin irritation/excoriation: red or darker pink, moderate irritation. F. Record review of Transfer Summary dated [DATE] indicated the following: Resident appears to have a severe [MEDICAL CONDITION] (a potentially serious bacterial skin infection which appears as a swollen, red area of skin that feels hot and tender) from hip to knees bilaterally (on both sides) including to groin. Also an anal wound that is open and has a foul odor to it. Transferred to the hospital. G. Record review of facility Incident Report dated [DATE] indicated the following: 1. [DATE]: Therapist evaluated skin and found wound in between gluteal cheeks to be sore and inflamed, area felt solid to the touch. Reported finding to (Name of RN #1) who stated it was excoriation r/t (related to) diarrhea and she left a note for the physician (this administrator can find no note for the doctor). 2. ,[DATE]: RN #1 charts that resident's excoriation is greatly improved. 3. (Name of RN #1) had no explanation for why she did not document (how she followed up on R #1's complaints and information given to her by other staff members). (Name of RN #1) stated, 'I can see I need to improve my documentation.' (Name of RN #1) terminated from employment on [DATE]. H. On [DATE] at 3:18 pm, during interview with the Administrator, she stated that R #1 initially had some excoriation to his sacral area as a result of loose stools. She stated that the PTA was the staff member who discovered the hardening of the gluteal area and notified the nurse. The Administrator stated that during her investigation which included resident and staff interviews and documentation review, she didn't feel that RN #1 tended to the residents needs and she (RN #1) failed to go in and assess what was reported to her by the therapist and she blew it (concerns about R #1's wounds and pain) off as previous excoriation from the diarrhea. The Administrator stated that she could find no documentation to indicate that the nurse appropriately responded to the report from the PTA regarding the wound in between the buttocks and the hardening to the gluteus and resulting pain that R #1 had been reporting. I. On [DATE] at 3:20 pm, during interview with the Corporate Nurse/Acting DON (Director of Nursing), she stated that RN #1's employment was terminated because she failed to provide care based on the standards of practice. The Corporate Nurse stated that RN #1 was unable to provide documentation to indicate that care was provided, that she'd followed up on R #1's complaints of pain and that she'd notified the physician of these concerns. J. On [DATE] at 3:56 pm, during interview with PTA, she stated that on [DATE], she went into R #1's room several times as he'd been refusing to participate in therapy due to his pain. PTA stated that R #1 and his sister informed her that he was having a lot of pain in his buttock area in addition to a wound in between the buttocks. PTA stated that at this time, she assessed the buttock and anus area and noted a hardened area between R #1's anus and testicles. PTA stated that she informed the resident and his sister that they should speak to the physician about these concerns. PTA stated that the sister asked her to inform the nurse about these concerns as, when the sister informed RN #1, she (the sister) didn't feel that RN #1 was appropriately responding to the concerns when she had been notified of them previously by R #1 and his

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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F 0224 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 1) sister. PTA stated that, as soon as she left R #1's room, she notified RN #1 of the concerns and RN #1 stated that she was already aware of the concerns and had left a note for the physician. PTA stated that when she spoke to RN #1, RN #1 did not seem very concerned and she (PTA) was concerned about whether she would follow through and address R #1's complaints. K. On [DATE] at 11:50 am, during interview with RN #1, she stated that she was one of the nurses who cared for R #1. RN #1 stated that shortly after R #1 was admitted , his sister who had been his caregiver informed her that he had some redness to his bottom and that she had been using Vaseline on this area. RN #1 stated that during R #1's stay at the facility, she never noted the red, excoriated area to be an open wound and that the area just appeared to be irritated due to frequent diarrhea. RN #1 stated that when she left for the day on [DATE], R #1's buttock area still appeared to just be irritated. She stated that she never noted a foul odor coming from the excoriated area and that she did not note any reddened, hard area from R #1's hip to knee area. She was unable to indicate how, over the course of one day, the wound would have gone from slight irritation to a 2 inch open wound with foul odor or how the reddened, hard area could have extended to the knees when it was only a small hardened area of the buttock the day before. RN #1 verified that she was terminated after management conducted an investigation and determined that she did not provide adequate care and that the night nurse who cared for R #1 after RN #1 did note a lot of redness and swelling in addition to the open wound of the buttock and perineal area. RN #1 stated that she was not sure if she notified R #1's physician of the skin concerns but that the facility procedure was that any time a physician was notified, this was documented in the nursing progress notes. L. Record review of (Name of Hospital) Medical Record indicated the following: 1. Physician History and Physical dated [DATE]: The patient presents with a complaint of low blood sugar, skin infection. Location of the complaint is generalized, left buttock. The onset is unknown. Clinically septic (bacteria in the bloodstream). 11:48 am: After lengthy conversation with family, they elected no further CPR at this time. Time of death: 11:36 am. Preliminary cause of death: [MEDICAL CONDITION] (bacteria in the bloodstream). 2. Blood culture dated [DATE] indicated a positive result for [MEDICAL CONDITION]. M. Record review of Disciplinary Action for RN #1 dated [DATE] indicated the following: Failure to appropriately assess a resident. Failure to ensure resident received appropriate intervention resulting in negative outcome. Failure to follow facility protocol for incident reporting and follow up. Poor attitude towards co-workers and families. Action Taken: termination .
F 0280 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**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 observation, interview and record review, the facility failed to revise care plans to incorporate significant aspects of needed care, for 2 (R #s 3 and 5) of 5 (R #s 1, 2, 3, 4 and 5) residents reviewed during a complaint investigation. Residents with a pressure ulcer (bed sore) or type 2 diabetes mellitus (a chronic illness of poor blood glucose level control) did not have related focus, goal or intervention sections in their care plans. If a care plan is not comprehensive, residents have the potential to receive care that is inconsistent or inadequate to help them achieve their optimal state of health. The findings are: A. Record review of R #3's computerized active [DIAGNOSES REDACTED]. B. Record review of R #3's physician's orders [REDACTED]. C. Record review of Interdisciplinary Team (IDT) progress notes for R #3 found a note dated 12/16/16 stating Pressure ulcer/Right heel. Stage II (shallow) pressure related injury present to right heel, area has improved compared to last week. D. On 12/22/16 at 10:15 am, a routine dressing change to R #3's right heel wound by the wound nurse was observed. The wound was found to be present, though scabbed over. E. Record review of R #3's care plan found a Potential for skin breakdown focus area, dated 01/15/16, with the goal of Maintain intact skin integrity by 04/15/16. No updating of the care plan occurred after her development of a pressure ulcer, with appropriate interventions to promote healing or prevent additional ulcers. F. Record review of R #5's computerized active [DIAGNOSES REDACTED]. G. Record review of R #5's physician orders [REDACTED]. H. Record review of R #5's medication administration records for November and December 2016 found that she received both [MEDICATION NAME] (a long acting form of insulin) and [MEDICATION NAME](rapid-acting type of insulin) on a daily basis. I. Record review of R #5's care plan (undated) found no focus section or interventions related to management of her diabetes. J. On 12/22/16 at 12:30 pm, during interview with the interim Director of Nursing, she verified that R #3 does not have a pressure ulcer addressed in her care plan, and that R #5's diabetes management is not addressed in her care plan. She confirmed that she would expect to see both issues addressed in the care plans.