STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	325125	A. Building B. Wing	04/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bear Canyon Rehabilitation Center	5123 Juan Tabo Boulevard NE Albuquerque, NM 87111

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35632 Based on interview and record review, the facility failed to ensure that residents are free from neglect for 1 (R #10) of 3 (R #10, 11 and 12) residents reviewed for death by: not providing any intervention for R #10 when she began to experience anxiety around feeling like she was short of breath. This deficient practice likely resulted in R #10 feeling extreme anxiety, distress and that she was being ignored within the 24 hours before her passing. The findings are: A. Record review of dashboard in the medical record for R #10 indicated that R #10 was admitted on [DATE] and passed on [DATE]. B. Record review of the medical diagnoses for R #10 revealed the following: Pneumonitis (general inflammation of lung tissue) due to inhalation of food or vomit, Dysarthria (motor speech disorder) and Anarthria (a loss of control over the speech muscles and is a severe form of Dysarthria), Dyspagia (difficulty with swallowing), Gastro-Esophageal Reflux Disease (when stomach acid repeatedly flows back into the tube connecting your mouth and stomach), Depression (is a common and serious mental illness that affects your mood and interest in life), Anxiety Disorder (persistent and excessive distress that affects daily life), Chronic Respiratory Failure with Hypoxia (when your respiratory system is unable to remove enough carbon dioxide from your blood, causing it to build up in your body), Hernia (part of your insides bulges through an opening or weakness in the muscle or tissue that contains it), Osteoarthritis (inflammation of one or more joints. It is the most common form of arthritis that affects joints in the hand, spine, knees and hips). This is not an all inclusive list. R #10 did not have Dementia (symptoms affecting memory, thinking and social abilities severely enough to interfere with your daily life) listed as a diagnosis. C. Record review of the Minimum Data Set (MDS) on [DATE], indicated that R #10 was noted as having a BIMS of (Brief Interview for Mental Status) of 15 (,d+[DATE] severely Impaired cognition, ,d+[DATE] moderately impaired, 13 -15 intact cognition) 15 meaning no cognitive deficit. D. Record review of R #10's medical record indicated that R #10 was on Hospice for Chronic Respiratory Failure starting [DATE]. E. Record review of the physician orders indicated that R #10 had an order for the following: -Continuous 4 liters of oxygen (O2) on admission [DATE]. (continued on next page)

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

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F 0600 Level of Harm - Actual harm Residents Affected - Few	-Ativan (Lorazepam 0.5 mg) give on tablet by mouth every 4 hours as needed for anxiety [DATE]. -Morphine Give 0.25 mg by mouth every 1 hour as needed for pain and SOB (shortness of breath)[DATE]. F. Record review of the nursing progress notes dated [DATE] at 14:02 (2:02 pm) indicated the following, pt (patient) called 911 at least 8 times during shift and was alternating with calling the son. She was telling 911 she can't breathe on which fire department showed up but she was doing ok on their assessment. Diversional therapy (client centered practice [that] recognizes that leisure and recreational experiences are the right of all individuals) was provided to pt but to no avail. Pt able to use call light and make needs known although for the most times would rather yell instead. Hospice came to see pt and changed medications, d/c (discharge) pravastatin (to help lower bad cholesterol and fats) and start lasix for edema (reduce extra fluid in the body). Will continue to monitor pt . regular. Temperature 98.4 Route: Forehead (non-contact) Pulse 95 Regular, Respirations 20 regular, O2 93.0 % Oxygen via Nasal Cannula, Blood Pressure ,d+[DATE] G. Record review of the nursing progress notes dated [DATE] at 18:35 (6:35 pm) City Fire Lieutenant contacted writer (Former Unit Manager) and stated that pt from our facility continues to call 911. Writer personally checked on pt several times throughout the day d/t (due to) being notified early this morning that pt was doing this [calling 911]. Pt was never noted in distress of any kind. Writer was notified by Lieutenant that if pt continues to call 911 the police department would be contacted to come to facility and cite the person in charge of pt. Writer notified pt's POA (Power of Attorney), (name of person) via telephone. (name of POA) stated he will contact pt to ask her to stop calling 911. H. Record review of the medical record did not reveal that any other assessments were completed for R #10 on [DATE]. I. On [DATE] at 11:17 am, during an interview with son/POA, he stated that R #10 had only been at the facility for a short time. On [DATE] she was complaining to him and calling 911 telling them that she couldn't breathe. She called him around 11 times that day. He stated that he also called 911 and informed them that his mother told him that she was having a hard time breathing. He stated that he was not sure if emergency medical services ever went out to the facility to check on her. He stated that he did talk to the facility several times that day and they assured him that she was medically fine and was just having anxiety. He stated that at 4:30 am [[DATE]] the facility called him and told him that she had died . He was shocked and upset because he believed the facility that she was just having anxiety. J. On [DATE] 11:50 am, during an interview with the Hospice Case Manager, she stated that R #10 was admitted [DATE] with a diagnosis of chronic respiratory failure and hypoxia. She stated that on [DATE] the [hospice] nurse went to the facility to see her at 3:30 pm. She assessed her and noted that she was anxious and wanted to go home. There is a note about R #10 calling the son and 911 all day. She had Lorazepam on order for anxiety but the nurse did not indicate in her note that she requested that R #10 take the anxiety medication. Her oxygen saturation level was 90% on 4 liters. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	K. On [DATE] at 8:04 am, during an interview with POA and family member, he stated that on the day she passed she kept calling 911 and they called him so he could get her to stop calling 911. He said that the last phone call from the facility to him came in around 9:00 pm. The facility asked him to talk to R #10 and to re-assure her that she was fine. He called is mom and told her that the facility had checked her out and that she was fine. He stated that he should have gone down there and saw her in person but the facility kept telling him that she was fine. L. Record review of the 911 transcripts (no times were documented on the transcripts) of some of the calls made by R #10 revealed the following: R #10 told the 911 operator over 20 times during the multiple phone calls, that she could not breathe and needed help. The operator called the facility and spoke with male #1 who stated the following: Male #1: answered phone and stated name of the facility and asked how he could help the person. Operator stated that one of the residents from the facility was calling them and the operator wasn't clear what the resident needed. Male #1 stated that there wasn't anything urgent at the facility and they have nurses and full staff. Operator told Male #1 residents name and he stated that they have been having this problem, and that this patient had behavioral issues. Operator asked if Male #1 would go check on her because she keeps calling. Her son/POA called 911 and told the operator that his mother kept calling him and telling him she couldn't breathe and asked the operator to send an ambulance to check on her. Operator called the facility back after the phone call with her son/POA. Male #2 answered the call and the operator told him that the son of one of the residents at the facility just called them and said that his mom was requesting 911. Operator stated that he was reaching out to see what the situation was before sending anyone out and stated R #10's name. Male #2 said yeah, just a senile patient with mental issues and things of that nature. Male #2 told the operator that there were nurses and CNAs on the halls and there wasn't anything urgent. Operator stated okay and to call 911 if they needed anything and the call ended. The last transcribed call that was made to 911 Operator was from the facility [on [DATE]] indicating that they had a resident (R #10) that had gone unresponsive. She still had a pulse and barely any chest rise. M. Record review of the nursing progress notes indicated that on [DATE] Pt cardiac arrested at 0340, (am) this nurse initiated CPR with the aid of 4 other nurses, Emergency Medical Services (ems) called, ems took over code at 0345 . time of death 0420 (am). N. Record review of the Office of the Medical Examiners autopsy report indicated that the autopsy was completed on [DATE] and the cause of death for R #10 was atherosclerotic and hypertensive cardiovascular disease (is a heart problem that is caused by hardening of arteries), Other significant findings were amyotrophic lateral sclerosis (ALS is a nervous system disease that affects nerve cells in the brain and spinal cord and causes loss of muscle control). Manner of death was found to be natural. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	O. On [DATE] at 8:04 am, during an interview with POA and family member, he stated that he went into his mother's (R #10) phone and pulled the times from the phone for the 911 calls. The following are the times of the phone calls to 911: 1. 10:20 am lasted 10 min 35 secs 2. 10:45 am lasted 2 min 59 secs 3. 11:57 am 26 secs 4. 12:03 pm 1 min 16 secs 5. 12:08 pm 45 secs 6. 12:09 pm 6 min 35 secs 7. 12:49 pm 2 min 38 secs 8. 2:41 pm 9 min 42 secs 9. 3:04 pm 2 min 24 secs 10. 4:17 pm 6 min 43 secs 11. 4:45 pm 2 min 47 secs 12. 5:23 pm 11 min 32 secs 911 calls stop. The POA stated that after the 911 phone calls stopped he received a total of 18 phone calls from his mother and they stopped sometime around 9 pm. The POA stated that during those 18 phone calls to him from his mother he continued to reassure her that she was fine. He stated that if he were to describe his mother on the phone calls to him he would say she sounded desperate, overwhelmed, and frantic, stating she couldn't breathe. He stated that to his knowledge when his mother (R #10) was at a different facility they never made him aware that she called 911 and that this was a behavior for her. Yes, she did have panic attacks and anxiety before and was taking medications for this. He stated that the facility kept telling him that she was just anxious but otherwise fine. P. Record review of R #10's o2 saturations for the two days prior to R #10 passing are as follows: [DATE] 19:34 96.0 % Oxygen via Nasal Cannula [DATE] 13:58 93.0 % Oxygen via Nasal Cannula [DATE] 04:03 94.0 % Room Air [DATE] 23:53 95.0 % Oxygen via Nasal Cannula (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	[DATE] 19:54 95.0 % Oxygen via Nasal Cannula [DATE] 07:45 95.0 % Oxygen via Nasal Cannula Q. Record review of the Medication Administration Record (MAR) indicated the following: Ativan Tablet (Lorazepam) (used for anxiety) 0.5 mg give one tablet every 4 hours as needed for anxiety, start date was [DATE]. This medication was given a total of three times once on ,d+[DATE], ,d+[DATE] and ,d+[DATE]. There is no documentation of R #10 receiving this medication on [DATE]. Morphine Sulfate (used for pain) solution 20 mg, give 0.25 ml by mouth every 1 hour as needed for pain and SOB (shortness of breath) start date [DATE]. This medication was not given while resident was in the facility. U. On [DATE] at 11:29 am during interview, the Center Nursing Executive (CNE) stated that she (R #10) had called 911 days prior to [DATE]. He stated that he is not familiar with this resident because he was not working at this facility at that time. He stated that looking at the information that the facility had at that time (vitals) she didn't appear in any distress. He did wonder why no medication was given when it was already ordered for her, because she was on hospice. He stated that because this was occurring all day for her it would have been appropriate to give her the ordered, as needed medication. He said that she had morphine on order as needed, and Ativan on order as needed. Since she was anxious and stating she was short of breath morphine would have been more appropriate since that medication can help relax smooth muscles and she wouldn't have felt so short of breath. The CNE did find that Ativan was signed off in the narcotic book at 8:00 pm on [DATE] for R #10 but wasn't put on the MAR as actually being given so it wasn't clear. He also stated that if EMS comes out and they assess a resident as being medically stable they will not take them to the hospital, even if they want to go. EMS comes out and they can make a determination of whether they are appropriate to go out or not. He said that he disagrees with this but he has encountered this in the past. R. On [DATE] at 5:05 pm during an interview with the former Unit Manager (UM), she stated that she remembers checking on R #10 and her oxygen saturation wasn't low and she did not appear to be in any distress. She stated that R #10 did not tell her she was short of breath or having a hard time breathing and she did not have a conversation with her about it. When asked what R #10 was doing when she went into the room to assess/check on her and UM stated that she was lying in bed, resting. She did not appear to be in any distress or short of breath. She did call the son to ask that he call his mother to request that she stop calling 911. She stated that EMS came out at least once maybe twice. She stated that she didn't remember if the physician was ever called, but probably not because the resident had stable vitals. She did not give any medication to the resident on [DATE] but was not sure if the nurse on duty had or not. .

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 35632 Based on record review and interview, the facility failed to ensure that residents received appropriate and safe transfer assistance for 1 (R #15) of 1 (R #15) resident reviewed for accidents. This deficient practice resulted in an unsafe transfer (move from one place to another) resulting in the resident sustaining a skin tear that required stitches. The findings are: A. Record review of the care plan indicated that R #15 was an extensive assist of 2 persons for transfers using a mechanical lift. Initiated on 07/28/21 and revised on 03/03/23. B. Record review of the SBAR (Situation-Background-Assessment-Recommendation) dated 03/03/23 indicated the following: Nursing observations, evaluation, and recommendations are: Patient refused use of Hoyer lift and threatened CNA (Certified Nursing Assistant). CNA lifted patient from bed into chair with stand assist of another CNA. After transfer a large skin tear was observed by the CNA's to the left lateral leg. (There had not been a skin tear to her leg prior to the transfer). C. Record review of the nursing progress notes dated 3/3/23 indicated that R #15 was taken to ED (Emergency Department) for stitches in LLE (Left Lower Extremity) for skin tear. Returned to facility 1400 (2:00 pm). Patient given lunch upon return, appetite fair. Pt c/o (complain of) severe pain given 10 mg oxycodone, then c/o 7/10 pain at 1800 given ibuprofen 600 mg. Pt requires repositioning in chair to alleviate pressure and for comfort. D. Record review of the nursing progress notes dated 3/3/23 indicated that resident returned from (name of) Hospital visit to the ER for an avulsion (tears/avulsion are caused by something sharp or rough tearing the skin and other tissues off the body) to the right lower extremity. Six sutures were placed, and per the hospital, paperwork sutures to be removed in one week. E. On 04/24/23 at 2:51 pm, during an interview with Power of Attorney (POA) she stated that R #15 told the Certified Nursing Assistants that she didn't want to use the Hoyer (mechanical) lift to get up. So the CNA's tried to accommodate her. She was moved without the Hoyer lift and she sustained a skin tear that required a visit to the ER and stitches. F. On 04/25/23 at 4:07 pm, during an interview with the Center Nursing Executive (CNE), he stated that his understanding of the accident was that she refused to allow CNA's to use the Hoyer lift. He stated that the CNA's felt like they had to accommodate her instead of saying, no, for your own safety we have to transfer you this way. He stated that she has been a Hoyer lift for a long time so she wasn't new to having to use the Hoyer lift.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are free from significant medication errors. 35632 Based on record review and interview, the facility failed to obtain and administer medications to 2 (R #12 and 15) of 2 (R #12 and 15) residents reviewed for medication errors. This deficient practice could likely result in residents not receiving medication as ordered for treatment of pain, infection and disease. R #15 Oxycodone for Pain: A. Record review of the physician orders indicated the following orders oxycodone 20 mg, give 1 tablet by mouth every 12 hours for Pain. Start date 03/01/23. B. Record review of the nursing progress notes dated 3/2/23 at 8:15 am, indicated that the nurse spoke with Nurse Practitioner about R #15's 20 mg of Oxycodone and informed her about medication not being filled yet or delivered. Oxycodone 5 mg give two tablets every 6 hours for pain. This nurse was trying to explain to resident with med tech present the new medication regimen for pain management, resident wasn't interesting in hearing what I had to say she waved me off. C. Record review of the Medication Administration Record (MAR) for 03/23 indicated that R #15 did not receive her 20 mg tab of oxycodone every 12 hours on 03/01/23 at 2000 (8 pm) and at 8 am on 03/02/23. D. Record review dated 3/2/23 at 13:12 (1:12 pm) indicated that a call was made to the pharmacy regarding Oxycodone 20 mg and the oxycodone 5 mg. Was informed by pharmacy staff that medication is to be delivered on night run - anticipate delivery around 2130 (9:30 pm). Informed pharmacy staff that would not keep us in line with scheduled medication. Medication was due at 8 am and still has yet to be given. Pharmacy to make arrangements to have it delivered within two hours. F. On 04/24/23 at 2:51 pm, during an interview with the Power of Attorney for R #15, she stated that the lack of action with the medications was upsetting. She stated that after she had returned from the hospital the Omni Cell (has common medications available when a resident needs it) was broken and she thinks a lot of the management were at a conference and didn't get fixed. This occurred at the beginning of March. She stated that R #15 was very upset the night or 03/01/23. G. On 04/25/23 at 4:07 pm, during an interview with Center Nursing Executive (CNE) during an interview he stated that there was a problem with the Omni Cell. He said that the Omni Cell was broken and he was notified of this on Tuesday the 02/28/23. A technician was coming out on Tuesday and showed up on Wednesday morning. He discovered that he needed a part. By Friday 03/03/23 the part had come in and it was up and working. R #15 arrived after hours on 03/01/23 and because the Omni Cell was broken and the staff didn't know what process to follow R #15 did not receive her 20 mg of Oxycodone. He stated that the process for a resident coming in after hours is that the on call physicians have to be called it is after hours. The on call physician sends in a script to pharmacy. If the medications aren ' t going to come in then they have to get an authorization code for the Omni cell but the Omni cell was broken. R #15 Ear Medications (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	H. Record review of the hospital discharge orders indicated that a new order for ciprofloxacin opthalmic 5 drops in right ear 2 times per day for 14 days to start on 03/01/23 and end on 03/15/23 per ENT (Ears, Nose and Throat) consult for concerns of mycoplasma bullous myringitis (is a condition where painful blisters form in the ear). I. Record review of the facility physician orders did not reveal an order for ciprofloxacin opthalmic 5 drops in right ear 2 times per day for 14 days J. Record review of the nursing progress notes dated 03/01/23 indicated that in a report from nurse at hospital resident c/o (complain of) right ear pain upon leaving the hospital, informed this nurse in report. Ear drops to right x14 days for pain and drainage. K. Record review of the MAR for 03/23 indicated that an order on 03/01/23 for Debrox Solution 6.5 % (Carbamide Peroxide is used to treat earwax buildup). Instill 5 drop in right ear two times a day for ear pain for 14 days was ordered. L. Record review of an after visit summary from (name of hospital) dated 03/03/23 indicated an order for ofloxacin 0.3% otic solution (for ear infection) place 10 drops in right ear for 10 days. M. Record review of the nursing progress notes dated 03/03/23 indicated that the provider was notified of the return visit and new order for the antibiotic ear drop and placed on the MAR. N. Record review of the facility physician orders: Ofloxacin Otic Solution 0.3 % (for ear infection treatment) Instill 10 drops in right ear in the morning for ear infection for 10 days. Start date 03/04/23. R #15 did not receive this medication because she went back out to the hospital. O. On 04/24/23 at 2:51 pm, during an interview with Power of Attorney (POA) she stated that R #15 had an ear infection and they did not give her the medication that was prescribed. She ended up with a severe ear infection when she went back tot he hospital. P. On 04/25/23 at 7:52 am, during an interview with the Ombudsman she stated that she is familiar with R #15 and that the POA was concerned that they were mistreating her. She stated that she was told that R #15 missed medications because the Omni Cell was broken and she wasn't getting ear drops that she needed for an infection in her ear. Q. On 04/25/23 at 4:07 pm, during an interview with Center Nursing Executive (CNE) during an interview he stated that when a resident goes out to the emergency room and they come back they usually aren't handed copies of medical records. About 50 % of the time they get hospital medical records. He stated that for R #15 her ear drops weren't in the original packet that came in and was verified by the physician. He stated that a second set of orders came in for the ear drops but they didn't see those orders and they didn't get verified. He said not sure when the physician was notified of the orders but orders for the ear drops did come in on 03/04/23. She did not ever get them because she went back out to the hospital. R #12 R. Record review of R #12's face sheet indicated that she arrived the evening of 02/27/23. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	S. Record review revealed that R #12 missed the following medications on 02/28/23: Allopurinol Oral Tablet (Allopurinol used to gout and kidney stones) Give 150 mg by mouth in the morning for gout-Start Date- 02/28/23 at 8:00 am. Bupropion HCl ER (extended release is used for depression) tablet 12 hour 150 mg. Give 1 tablet by mouth in the morning for depression. -Start Date- 02/28/23 at 8:00 am. Eliquis Oral Tablet 5 MG (Apixaban used to prevent serious blood clots from forming). Give 1 tablet by mouth two times a day for A-fib (Atrial fibrillation is an irregular and often very rapid heart rhythm (arrhythmia) that can lead to blood clots in the heart) -Start Date-02/28/23 at 8:00 am. Furosemide Oral Tablet 40 MG (Furosemide helps the body get rid of excess water) . Give 1 tablet by mouth in the morning for diuresis. -Start Date- 02/28/23 at 8:00 am. Nystatin External Powder 100000 UNIT/GM (Nystatin Topical used to treat skin rashes and infections) Apply to area topically two times a day for fungal rash. -Start Date- 02/28/23 at 8:00 am. Sensipar Oral Tablet 30 mg (Cinacalcet used to treat chronic kidney disease and used to treat high levels of calcium in the blood). Give 1 tablet by mouth in the morning for hypercalcemia (too much calcium in your blood). -Start Date-02/28/23 at 8:00 am. T. On 04/26/23 at 12:40 pm, during an interview with Center Nursing Executive (CNE), he stated the Omni Cell doesn't hold all meds, it holds a lot of common of meds and a lot of the medications the R #12 was on are fairly common. Looks like she didn't get some of her medications at least for the day shift. He stated that February 28th 2023 is the day that the Omni cell was broken so this would be the reason she didn't get her medications on the 28th. They hadn't come in from the pharmacy and the Omni cell wasn't working.

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. 35632 Based on record review and interview, the facility failed to ensure that medical records/medication administration record (MAR) were complete and accurate for 1 (R #10) of 1 (R #10) resident reviewed for death. This deficient practice had the potential to negatively impact the continuum of care by nursing staff not knowing whether a medication was given to a resident due to missing documentation on the MAR. The findings are: A. Record review of the Medication Administration Record (MAR) indicated the following: Ativan Tablet (Lorazepam) (used for anxiety) 0.5 mg give one tablet every 4 hours as needed for anxiety, start date was 05/06/22. This medication was given a total of three times once on 05/06, 05/08 and 05/10. B. On 04/27/23 at 9:27 am, during an interview with Center Nursing Executive (CNE) he stated that he found in the narcotic sign off book that an Ativan was pulled from the medication pack for R #10 on 05/11/22 at 20:00 (8:00 pm). However, it was not documented on the MAR as being given. He stated that there is no indication that it was wasted (meaning not given) so it make sense that she got the pill. He stated that errors like this do happen because there are two steps to the process when giving a PRN medication and sometimes nursing staff get distracted.