STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	325131	A. Building B. Wing	05/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Spanish Trails Rehabilitation Suites	1610 Renaissance Blvd NE Albuquerque, NM 87107

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. 41988 Based on record review and interview, the facility failed to provide ADL (Activities of Daily Living) assistance for baths/showers for 1 (R #1) of 2 (R #'s 1 and 3) residents reviewed for ADL care. This deficient practice is likely to affect the dignity and health of the residents. The findings are: A. Record review of R #1's physician orders dated 10/18/22 revealed, BATHING Monday/Friday AM Shift. B. Record review of R #1's census page dated 04/01/23-04/30/23 revealed R #1 was out of the facility on 04/06/23-04/07/23, 04/10/23-04/14/23, and 04/17/23-04/26/23. R #1 was in the facility for all other days. C. Record review of R #1's Point Of Care (POC- ADL Tracking Form located in the Electronic Health Record) response dated 04/01/23-04/30/23 revealed R #1 was only offered 1 bed bath/shower on 04/14/23 out of 3 opportunities. D. Record review of R #1's shower review forms dated 04/01/23-04/30/23 revealed R #1 was only offered 1 bed bath/shower on 04/14/23 out of 3 opportunities. E. Record review of R #1's Point Of Care Response dated 05/01/23-05/10/23 revealed R #1 was offered 0 bed bath/showers out of 3 opportunities. F. Record review of R #1's shower review forms dated 05/01/23-05/10/23 revealed R #1 was only offered 2 bed bath/showers on 05/05/23 and 05/08/23 out of 3 opportunities. G. On 05/08/23 at 4:45 pm during an interview with R #1, he stated, I barely got a bed bath today [05/08/23]. I didn't get one for two weeks. R #1 confirmed he prefers two bed baths/showers a week. H. On 05/09/23 at 2:21 pm during an interview with Certified Nursing Assistant (CNA) #1, she stated resident bed baths/showers are documented in the POC response and shower review forms. CNA #1 also stated that R #1 does not usually refuse bed baths/showers. I. On 05/09/23 at 5:15 pm during an interview with the Assistant Director of Nursing (ADON) #1, she confirmed R #1 was not offered as many bed baths/ showers as he should have been.

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.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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Spanish Trails Rehabilitation Suites	1610 Renaissance Blvd NE Albuquerque, NM 87107

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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 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41988 Based on record review and interview, the facility failed to provide treatment and care in accordance with professional standards for 1 (R #1) of 1 (R #1) resident reviewed by 1. Not assessing and monitoring R #1 for injury after (2) falls likely resulting in a delay in treatment for (4) days. 2. Not notifying the Physician of change in condition (increase in pain) or providing effective pain management following (2) falls resulting in an open fracture (fractured bone is external environment) of R #1's lower right leg. These deficient practices likely resulted in R #1 experiencing significant pain and delayed treatment. The findings are: A. Record review of R #1's Face Sheet revealed R #1 was admitted into the facility on [DATE] with diagnosis of Paraplegia unspecified (paralysis of legs and lower body). List of diagnosis is not all inclusive. B. Record review of R #1's Nursing Progress Notes date 04/13/23 at 4:14 pm revealed, At 3:57 pm, EMS [Emergency Medical Services] via stretcher take resident back to [Name of Local Hospital] for altered mental status, EMS did state, that pt [patient] does not make sense while communicating with res [resident (R #1)] for extended period of time 25 minutes. Res. [R #1] first found on floor beside bed, transportation stated, res. [R #1] flopped himself out of W/C [wheelchair] onto floor and now bleeding, upon assessment, writer sees resident moving in center of bed and blood is seen on floor, writer is asking resident [R #1] where is he bleeding from, resident more concerned about his trash can being close to bed. Writer asks resident to turn over, writer sees two open areas that are bleeding under bilateral buttocks, behind thighs, areas, cleansed and dressings applied. Res. [R #1] states did not hit his head. Vitals Taken, within normal limits. Resident not making sense to writer nor staff, incident noted. 30 minutes from this fall, writer is then called to res. [R #1] room due to pt. [patient] on the floor under roommates bed, moving around throughout floor in room, writer ask, what are you doing, res. [R #1] states, trying to get help, writer informed, you always call us on the call light and we use the hoyer [lift], why are you falling onto the floor, resident did not answer, he asking for help to get onto the bed. Any questions that staff ask, resident [R #1] ignores and wants his personal items next to him. Vitals taken, blood pressure elevated, all other WNL [Within Normal Limits]. Writer called on call [Name of Provider], received order to send res. [R #1] out to ER [emergency room] for further evaluation. Progress note did not identify that R #1 was assessed for injury to R #1's lower extremities. C. Record review of the Physician Progress Note dated 04/13/23 revealed Nursing staff called to report the patient [R #1] has returned from the hospital today and he continues to be confused and at this time nursing staff is requesting that the be patient be transferred to the emergency department for further evaluation and management. Progress Note did not identify concern or request for evaluation related to R #1's recent falls. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0684 Level of Harm - Actual harm Residents Affected - Few	D. Record review of R #1's Census Page revealed R #1 returned from the hospital to the facility on [DATE] at 2:20 pm. E. Record review of Physician progress note dated 04/14/23 revealed Patient returned from the hospital on 4/13 [23] but was found on the floor twice yelling for help. He was helped back to bed and nursing staff overnight reported seemed altered so oncall was notified and recommended he go back to the ER. He stated he was trying to walk yesterday night. He thought he could walk. Paperwork from his return to ER was reviewed and labs show no abnormalities, CXR (chest X-ray), CT (computed tomography; scan X-ray inside body) was all negative but UA (urinary analysis) was positive. F. Record review of R #1's medical record did not identify any progress notes or assessment of R #1 on 04/15/23. G. Record review of R #1's Weekly Skin Check dated 04/16/23 at 3:26 am revealed no documentation of injury or concerns related to R #1's right foot/lower leg. H. Record review of R #1's Nursing Progress Notes dated 04/16/23 at 11:15 am revealed, WOUND ON RIGHT FOOT is whipping [weeping]. Wound care done. Skin assessment done. [Name of Assistant Director of Nursing (ADON) #1] notified. see dr (doctor) communication. I. Record review of R #1's physician orders dated 04/13/23 revealed 1. acetaminophen (pain medication) [OTC] [Over the Counter] tablet; 325 mg [milligram]; Amount to Administer: 2 tabs; oral. 2. oxycodone - Schedule II tablet; 15 mg; Amount to Administer: 1 tab; oral. J. Record review of R #1's Medication Administration Record (MAR) dated 04/13/23-04/17/23 revealed the following: 1. R #1 was administered Acetaminophen 5 times on 04/16/23 with 3 out of the 5 administrations resulting in Somewhat Effective pain reduction. R #1 received Acetaminophen dose on 04/17/23. 2. R #1 received Oxycodone (medication used to treat pain) 2 times on 04/14/23, 1 time on 04/15/23, 3 times on 04/16/23 with 1 dose being Somewhat Effective, and 1 time on 04/17/23 that was Somewhat Effective. Pain scale was marked as 0 for both days. K. Record review of R #1's Change in Condition Skin Check dated 04/17/23 at 5:25 am revealed, Bruise and swelling right lower leg and foot. L. Record review of R #1's Physician Progress Note dated 04/17/23 at an unknown time revealed, Chief Complaint/Nature of Presenting Problem: He [R #1] is seen today in his room by the request of nursing who is concerned because his right foot has been inverted (facing in) swollen and bluish in color since a fall approximately 48 hours ago. He [R #1] reports he is having severe pain in the affected foot and I will increase his pain medication to Q 2 [every 2] instead of Q 6 [every 6] hours prn [as needed]. No x-rays have yet been ordered and I will order a right foot and right knee 2 views each. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	M. Record review of R #1's Nursing Progress Notes dated 04/17/23 at 9:05 am revealed, X-ray 2 view right foot and knee. Pain medication increased to Q4 [every 4] hours X [times] 48 hours for right foot and ankle pain. Right foot is swollen and black/purple in color. Foot is pointed outward. Received order [from provider] for PXR [x-ray]. Ordered STAT (immediately). N. Record review of R #1's Nursing Progress Notes dated 04/17/23 at 1:21 pm revealed, Sending to [Name of local Hospital] for fractured right ankle, non-emergent per [Name of Provider]. O. Record review of R #1's Hospital Documentation dated 04/17/23 revealed, Hospital Course By Problem: Open Fracture of the right distal tibia (lower leg) and fibula (bone in leg). Due to mechanical fall, reportedly 4 days PTA [Prior To Arrival]. P. Record review of R #1's Hospital Surgery Documentation dated 04/18/23 at 12:26 am revealed, PROCEDURE: 1. Application of external fixator (device use to stabilize bones), right lower extremity. 2. Closed reduction of distal tibia and fibula fracture, right side 3. Wound debridement (the removal of damaged tissue) down to the level of bone, right distal fibula. 4. Application of wound VAC (device used to heal wounds), right lower extremity. Q. On 05/08/23 at 4:42 pm during an interview with R #1, he stated, I broke my foot in 3 places. I tried to stand up [on 04/13/23 and fell]. I broke my leg and ankle. They [doctors at the hospital] said I lost 3 inches of bone. I was in pain for 4 days and I told my nurse [on 04/15/23, 04/16/23, and 04/17/23]. She [nurse on 04/15/23 and 04/16/23] didn't do a good job [managing R #1's pain] and I was in pain. My regular nurse [Registered Nurse (RN) #1] came back and sent me [to the ER] right away. The surgeon said he thought he might have to amputate [cut off (a limb) by surgical operation] it [R #1's right leg]. My pain was worse than 10 [0 meaning no pain, 10 meaning most pain, during 04/15/23-04/17/23]. As soon as she [RN #1] saw me [on 04/17/23], she [RN #1] called 911 right away. R. On 05/09/23 at 1:52 pm during an interview with RN #1, she stated, I was off on Sunday [04/16/23]. I'm off Thursday-Sunday. His [R #1's] foot was purple, swollen, and facing in. I read some other people's [nursing staff] notes where they [nurses] saw a change [in R #1's foot on 04/15/23 and 04/16/23]. I was told that it [R #1 fell and injured his foot] was on Thursday [04/13/23], and it [bruising and swelling of R #1's foot] would have happened a couple of days ago. We got the x-rays, and I told the ADON [Assistant Director of Nursing], I notified the family, and the x-rays came back. He [R #1] complained of pain [on 04/17/23]. RN #1 confirmed an x-ray should have been ordered sooner than it was for R #1. S. On 05/09/23 at 3:56 pm during an interview with RN #2, she stated, I'm not aware if he [R #1] fell [to injure his foot]. I believe I sent a picture [of R #1's deformed foot on 04/16/23 to [Name of ADON #1]. Usually, I will send pictures if it's bad. Sunday (04/16/22), we don't have any doctor's and I'm not sure why [R #1 wasn't sent to the hospital until 04/17/23]. RN #2 confirmed she did not request an x-ray order for R #1 but she did send a picture of R #1's photo to ADON #1 on 04/16/23. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	T. On 05/09/23 at 4:12 pm during an interview with RN #3, she stated, Yeah, it [contacting the provider for R #1's increase in pain due to a fall on 04/13/23] should have been done by the previous nurse [RN #2] because it [R #1's increase in pain and change of right foot's appearance] happened during her [RN #2's] shift [on 04/15/23 and 04/16/23]. I don't know why she [previous nurse] didn't do it. RN #3 confirmed that she remembers R #1 being in significant pain when she worked with him on 04/15/23 and 04/16/23. U. On 05/09/23 at 5:13 pm during an interview with ADON #1, she stated, He [R #1] fell on the 13th [04/13/23] and he [R #1] went back to the ER [on 04/13/23] when he was admitted [to the facility on [DATE]] because his mentation was not clear [R #1 was not alert and was confused]. We did an x-ray in house [on 04/17/23] and sent him [R #1] to the ER. We would want the provider to be called if we can't manage it [pain] and be effective. We called the provider on [04/17/23] to get a physician order [for an x-ray order and to be sent to the ER]. ADON #1 confirmed she was not sent a photo of R #1's foot by RN #2. ADON confirmed that she wasn't aware that R #1 wasn't assessed for injury as a result of the falls at theER on [DATE]. V. On 05/10/23 at 11:32 am during an interview with Medical Doctor (MD) #1, she stated, I don't see any note [by a provider that was contacted by the facility] until my note [on 04/17/23]. No one eyeballed [looked at resident's injury] him [R #1] by our staff since the 5th [04/05/23]. There's no note [by a clinical provider] that he [R #1] fell [on 04/13/23]. It [facility contacting a provider for x-ray and transfer to the ER] should not wait[ed] until Monday [04/17/23]. MD #1 confirmed that she was not notified that R #1 was also experiencing an increase in pain. W. On 05/10/23 at 12:04 pm during an interview with the Director of Nursing (DON), she stated, A provider should have been notified [of R #1's foot change and increase in pain], if he's [R #1] saying he's in pain. DON confirmed a clinical provider should have been contacted sooner for R #1's foot injury and was not. X. On 05/10/23 at 12:20 pm during an interview with Emergency Medical Technician (EMT) #1, He [R #1] was telling me [04/17/23] that he was in pain and that staff was told for several days that he was in pain and staff was putting it off. The nurse that day [RN #1] upped his pain medications that day and that only started on the 17th [04/17/23]. He [R #1] was sleeping and his leg was obviously deformed. The bruising had spread all the way to back of his calf. She [RN #1] wasn't sure when the injury happened and I guess he [R #1] had reported a fall 4 days prior [on 04/13/23] and he [R #1] was complaining of pain 4 days prior. Y. On 05/10/23 at 12:59 pm during an interview with the Director of Nursing (DON), she stated, The nurse gave him [R #1] Oxycodone, Trazodone [anti-depressant medication], and Baclofen [medication for muscle spasms on 04/15/23 and 04/16/23]. She [RN #3] thinks it's [R #1's pain medication being marked as somewhat effective, while not giving R #1 additional pain medication]. She gave him Tylenol (Acetaminophen) at 4:09 am that morning [04/16/23]. DON confirmed R #1 was requesting additional pain medication on 04/15/23 and 04/16/23.