STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	325042	A. BUILDING _____ B. WING _____	10/01/2014

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ST THERESA HEALTHCARE AND REHABILITATION CENTER	7900 CONSTITUTION AVENUE NE ALBUQUERQUE, NM 87110

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 0223 **Level of harm** - Immediate jeopardy **Residents Affected** - Few	**Protect each resident from all abuse, physical punishment, and being separated from others.** The facility failed to keep residents free from physical and verbal abuse for 1 (R #152) of 1 (R #152). On 09/25/14 at 12:58 pm, R #152 rolled her wheelchair into the office doorway where PA #1 was working on his charting. R #152 began saying, I want to go home! repeatedly. PA #1 at this time grabbed the resident's wheelchair with both hands and pushed R #152 backwards into the hallway. As he pushed R #152's wheelchair, he was yelling loudly and in an abusive tone at R #152, I am unavailable. I have no time for you! As PA #1 walked off, PA #1 kept saying in the same demeanor I am unavailable! PA #1 did not look for help for R #152. PA #1 returned and again said in an abusive demeanor, I have no time for you! repeatedly to R #152. No staff tried to stop or remove PA #1 from coming back to the resident. Staff did not make the Acting Manager (AM) fully aware of the situation. PA #1 was not removed from the facility immediately after the incident. This deficient practice resulted in an Immediate Jeopardy (IJ) being identified at the facility on 09/25/14 at 3:10 pm. The facility took corrective action by providing an acceptable Plan of Removal. Based on the plan, interventions included: 1. The Physician's Assistant (PA #1), was removed from the center and will be suspended from service until further notice and a full investigation has been completed. 2. The 6 patients/residents that were seen by PA#1 on 09/25/14 will be interviewed on 09/25/14 regarding any interactions they have experienced or observed with other patients/residents that were perceived by the patients as abusive. 3. Other current patients/residents who are identified via admission nursing assessment and/or MDS (Minimum Data Set) with a BIMS (Brief Interview for Mental Status) score of 13 or above as being able to understand and be understood will be interviewed by 10/01/14. 4. Current staff on duty will be interviewed regarding any interactions they have observed between patients/residents or staff will be reported immediately to HFLC (Health Facility Licensing and Certification) and thoroughly investigated per policy and procedure. 5. Current staff on duty will be in-serviced and documented on In-Service sign-in sheets on identification and immediate reporting of any abuse of neglect of patients/residents on 09/25/14. Other staff will be in-serviced prior to their next scheduled shift. Based on the Plan of Removal and observation, the IJ was lifted on 09/25/14 at 5:10 pm. This resulted in the scope and severity being reduced from a scope and severity of J to Level 2, Scope G. Based on observations, record review and interview, the facility failed to ensure that residents were free from abuse for 2 (R #87 and #152) of 2 (R #87 and #152). This deficient practice resulted to 1) prevent R #152 from being physically and verbally abused and 2) failed to prevent R #87 from being verbally abused. The findings are: Resident #152 A. On 09/25/14 at 12:58 pm, observation of the 400 Hall revealed R #152 rolled her wheelchair into the office doorway on 400 Hall where PA #1 was charting documents in resident's medical records. R #152 stated, I want to go home! repeatedly. PA #1, who was now in the doorway, used both hands to push R #152's wheelchair backwards into the hallway. As PA #1 pushed R #152's wheelchair PA #1 was yelling loudly and in an abusive tone at R #152, I am unavailable. I have no time for you! After pushing R #152's wheelchair out of the way, PA #1 walked off angrily around the corner to the dining room. In the same demeanor PA #1 kept saying, I am unavailable! while walking away. PA #1 did not look for help for R #152. The Director of Social Services, upon hearing the commotion, came up to R #152 to try and calm R #152 down and check on R #152. An observation at the nurses' station revealed there was one med tech, two nurses, and the Director of Nursing, (DON) all watched what had happened. No other staff came to check on R #152. B. On 09/25/14 at 1:04 pm, observation of the 400 Hall revealed PA #1 turned the corner from the dining hall onto the 400 hall. R #152 was still in the 400 hall trying to be calmed down by the Director of Social Services. PA #1 again stated in an abusive demeanor, I have no time for you! repeatedly to R #152, while walking past R #152 to the office where PA #1 was charting. No staff tried to stop or remove PA #1 from coming back and yelling at the resident. C. On 09/25/14 at 1:01 pm, observation of the 400 Hall and interview with PA #1, PA #1 walked over and stated to the surveyors in the same abusive demeanor, Just so you know R #152 hit me in the leg with R #152's wheelchair! R #152 has been abusive to me in the past! D. On 09/25/14 at 1:04 pm, an interview was conducted with PA #1. PA #1 stated, I have a lot of patience for everything! But when it comes to that I have no patience! I have no patience for abuse! E. On 09/25/14 at 1:31 pm, R #152 was interviewed. R #152 was asked about what happened with PA #1. R #152 stated, I want to go back home with my dog. The resident was crying and stated, I told (Name of PA #1) I wanted to go home and (name of PA#1) shoved me away. (Name of PA #1) said he's unavailable! (Name of PA #1) said he has no time! (Name of PA #1) shouldn't have shoved me! (Name of PA #1) has no right to shove me! No one has a right to shove me! I am pissed! (Name of PA #1) never has time! (Name of PA #1) always says I has no time! Why won't (name of PA #1) let me go home? I am in my 50's and I am in a nursing home! Welcome to my nightmare! F. On 09/25/14 at 1:40 pm, observation of the 400 hall revealed PA #1 was seeing residents on the 400 hall. G. On 09/25/14 at 1:57 pm, an interview was conducted with the Facility Manager (FM). The FM stated, PA #1 told me in passing that the R #152 had hit him with her wheel chair. The Director Social Services calmed her down. We have contacted the Medical Doctor (MD) to see if the MD could come and see her, but R #152 is calm now. R #152 is eating in the dining room. H. On 09/25/14 at 2:10 pm, observation of the 400 hall revealed that PA #1 was looking over medical records in PA #1's office. Resident #87 I. On 09/23/14 at 8:09 am, R #87 was interviewed. The resident was asked if they had been abused by staff a resident or by anyone. R #87 stated, Yes, Certified Nursing Assistants (CNA) CNA #1 and CNA #2 have. CNA #1 tells me to get up and go do it yourself. R #87 was asked when does this happen the resident stated, I ask if I can have a cocoa (beverage with chocolate) and (name of CNA #1) says get up and go and do it yourself, I have other residents. R #87 was asked can you tell me about CNA #2 R #87 stated, (name of CNA #2) is just rude. If I ask her for anything she tells me, what do you want now? Yesterday, (09/22/14) I told (name of CNA #2) that I needed my pain medication and it took an hour before (name of CNA #2) told anyone. It was too close to regular time so I had to wait longer. R #87 was asked if she had told anyone about CNAs #1 and #2 she stated, Yes, I have told (name of LPN #1). (Name of LPN #1) knows that it is hard for me to write with my nerves. So I did not fill out a formal grievance report.

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 0223 **Level of harm** - Immediate jeopardy **Residents Affected** - Few	(continued... from page 1) J. On 09/26/14 at 11:50 am, LPN #1 was interviewed. LPN #1 was asked if they had been made aware of any issues that R #87 had with CNA #1 and CNA #2. The LPN stated, Yes, they have not brought (name of R #87) food or drinks sometimes; R #87 told me that she thinks they believe she is more capable of doing things then she is. I talked to CNA #1 and told them that R #87 is a resident. We have to respect the residents. You have to answer R #87's light, and assist R #87 with all needs. They said they tried to encourage R #87 to do more on the resident's own. When asked if the incident had reported to administration, LPN #1 stated, I did not report this issue because I did not take it in a way that would suggest abuse. K. Review of the grievance log revealed no evidence of incident report concerning R #87, CNA #1 and CNA #2. L. Record Review of the facility's Abuse Prevention Policy effective date 08/31/07 revealed the following: 1. It is the policy of this center to do all within its control (sic) maintain the resident's right to be free from verbal, sexual, physical, and mental abuse . through the implementation of seven components. a. Training of employees on incident management system within 30 days of employment and annually . At a minimum training would include: an overview of potential abuse . Staff legal responsibility to report their knowledge related to allegations . including how to complete incident management report form . specific instructions on how to respond (appropriate interventions) to deal with aggressive and/or catastrophic reactions of residents, abuse . How to recognize signs of burnout, frustration and stress that may lead to abuse . The importance of protecting residents from potentially abusive situations . b. Prevention . Education of staff related to the need to communicate any concerns that they observe or that have been reported to them . Educating residents, families, and staff to the fact that reports may be verbal or written . Supervision of staff to identify inappropriate behaviors, such as . rough handling . All staff will be trained to report any such observations to the appropriate department head or charge nurse who will then report to the administrator. c. Reporting . All staff will be trained to report incidents immediately to the administrator . to include . abuse. Alleged violations and substantiated incidents will be reported to the state agency immediately.
F 0226 **Level of harm** - Immediate jeopardy **Residents Affected** - Few	**Develop policies that prevent mistreatment, neglect, or abuse of residents or theft of resident property.** The facility failed to implement their abuse policies and procedures for 1 (R #152) of 1 (R #152). On 09/25/14 at 12:58 pm, R #152 rolled her wheelchair into the office doorway where PA #1 was working on his charting. R #152 began saying, I want to go home! repeatedly. PA #1 at this time grabbed the resident's wheelchair with both hands and pushed R #152 backwards into the hallway. As he pushed R #152's wheelchair, he was yelling loudly and in an abusive tone at R #152, I am unavailable. I have no time for you! As PA #1 walked off angrily he kept saying in the same demeanor, I am unavailable! down the hallway and entered the dining room. PA #1 did not look for help for R #152. PA #1 returned and again he was saying in an abusive demeanor, I have no time for you! repeatedly to R #152, (who was still in the 400 hall trying to be calmed down), while walking back to the office. No staff tried to stop or remove PA #1 from coming back to the resident. Staff did not make the administrator fully aware of the situation. PA #1 was not removed from the facility immediately after the incident. This deficient practice resulted in an Immediate Jeopardy (IJ) being identified at the facility on 09/25/14 at 3:10 pm. The facility took corrective action by providing an acceptable Plan of Removal. Based on the plan, interventions included: 1. The Physician's Assistant (PA #1), was removed from the center and will be suspended from service until further notice and a full investigation has been completed. 2. The 6 patients/residents that were seen by PA#1 on 09/25/14 will be interviewed on 09/25/14 regarding any interactions they have experienced or observed with other patients/residents that were perceived by the patients as abusive. 3. Other current patients/residents who are identified via admission nursing assessment and/or MDS (Minimum Data Set) with a BIMS (Brief Interview for Mental Status) score of 13 or above as being able to understand and be understood will be interviewed by 10/01/14. 4. Current staff on duty will be interviewed regarding any interactions they have observed between patients/residents or staff will be reported immediately to HFLC (Health Facility Licensing and Certification) and thoroughly investigated per policy and procedure. 5. Current staff on duty will be in-serviced and documented on In-Service sign-in sheets on identification and immediate reporting of any abuse of neglect of patients/residents on 09/25/14. Other staff will be in-serviced prior to their next scheduled shift. Based on the Plan of Removal and observation, the IJ was lifted on 09/25/14 at 5:10 pm. This resulted in the scope and severity being reduced from a scope and severity of J to Level 2, Scope G. Based on observation, record review and interview, the facility failed to implement their abuse policies and procedures for 2 (R #87 and #152) of 2 (R #87 and #152). This deficient practice likely resulted to 1) prevent R #152 from being physically and verbally abused and 2) failed to prevent R #87 from being verbally abused. The findings are: A. Record Review of the facility's Abuse Prevention Policy effective date 08/31/07 revealed the following: 1. It is the policy of this center to do all within its control (sic) maintain the resident's right to be free from verbal, sexual, physical, and mental abuse . through the implementation of seven components. a. Training of employees on incident management system within 30 days of employment and annually . At a minimum training would include: an overview of potential abuse . Staff legal responsibility to report their knowledge related to allegations . including how to complete incident management report form . specific instructions on how to respond (appropriate interventions) to deal with aggressive and/or catastrophic reactions of residents, abuse . How to recognize signs of burnout, frustration and stress that may lead to abuse . The importance of protecting residents from potentially abusive situations . b. Prevention . Education of staff related to the need to communicate any concerns that they observe or that have been reported to them . Educating residents, families, and staff to the fact that reports may be verbal or written . Supervision of staff to identify inappropriate behaviors, such as . rough handling . All staff will be trained to report any such observations to the appropriate department head or charge nurse who will then report to the administrator. c. Reporting . All staff will be trained to report incidents immediately to the administrator . to include . abuse. Alleged violations and substantiated incidents will be reported to the state agency immediately. Resident #152 B. On 09/25/14 at 12:58 pm, observation of the 400 Hall revealed R #152 rolled her wheelchair into the office doorway on 400 Hall where PA #1 was charting documents in resident's medical records. R #152 stated, I want to go home! repeatedly. PA #1, who was now in the doorway, used both hands to push R #152's wheelchair backwards into the hallway. As he pushed R #152's wheelchair PA #1 was yelling loudly and in an abusive tone at R #152, I am unavailable. I have no time for you! After pushing R #152's wheelchair out of the way, PA #1 walked off angrily around the corner to the dining room. In the same demeanor PA #1 kept saying, I am unavailable! while walking away. PA #1 did not look for help for R #152. The Director of Social Services, upon hearing the commotion, came up to R #152 to try and calm her down and check on her. At the nurses' station there was one med tech, two nurses, and the Director of Nursing (DON) all watched what had happened. No other staff came to check on R #152. C. On 09/25/14 at 1:04 pm, observation of the 400 Hall revealed PA #1 turned the corner from the dining hall onto the 400 hall. R #152 was still in the 400 hall trying to be calmed down by the Director of Social Services. PA #1 again said an abusive demeanor, I have no time for you! repeatedly to R #152, while walking past R #152 to the office where PA #1 was charting. No staff tried to stop or remove PA #1 from coming back and yelling at the resident. D. On 09/25/14 at 1:01 pm, observation of the 400 Hall and interview with PA #1, PA #1 walked over and stated to the surveyors in the same abusive demeanor, Just so you know (name of R #152) hit me in the leg with R #152's wheelchair! (Name of R #152) has been abusive to me in the past! E. On 09/25/14 at 1:04 pm, PA #1 approached the surveyors and stated loudly and in an abusive manor, I have a lot of patience for everything! But when it comes to that I have no patience! I have no patience for abuse! F. On 09/25/14 at 1:31 pm, R #152 was interviewed. R #152 was asked what happened with PA #1. R #152 stated, I want to go

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F 0226 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 2) back home with my dog. As the resident was crying she also stated, I told him (PA #1) I wanted to go home and (name of PA #1) shoved me away. (Name of PA #1) said they were not unavailable! (Name of PA #1) He said they had no time! (Name of PA #1) shouldn't have shoved me! (Name of PA #1) has no right to shove me! No one has a right to shove me! I am pissed! (Name of PA #1) never has time! (Name of PA #1) always says I have no time! Why won't (name of PA #1) let me go home? I am in my 50's and I am in a nursing home! Welcome to my nightmare! G. On 09/25/14 at 1:40 pm, observation of the 400 hall revealed PA #1 was seeing residents on the 400 hall. H. On 09/25/14 at 1:57 pm, the Acting Manager (AM) was interviewed. The AM was asked if they knew about the incident that had occurred between PA #1 and R #152. The AM stated, (Name PA #1) told me in passing that the R #152 had hit PA #1 with her wheel chair. The Director Social Services calmed R #152 down. We have contacted R #152's Medical Doctor (MD) to see if they could come see the resident, but (name of R #152) is calm now. (Name of R #152) is eating in the dining room. I. On 09/25/14 at 2:10 pm, observation of the 400 hall revealed that PA #1 was looking over charts in his office. Resident #87 J. On 09/23/14 at 8:09 am, R #87 was interviewed. The resident was asked if they had been abused by staff, a resident, or by anyone. R #87 stated, Yes Certified Nursing Assistants (CNA) CNA #1 and CNA #2 have. CNA #1 tells me to get up and go do it yourself. R #87 was asked when does this happen the resident stated, I ask if I can have a cocoa (beverage with chocolate) and (name of CNA #1) says get up and go and do it yourself, I have other residents. R #87 was asked can you tell me about CNA #2 R #87 stated, (name of CNA #2) is just rude. If I ask her for anything (name of CNA #2) tells me, what do you want now? Yesterday, (09/22/14) I told (name of CNA #2) that I needed my pain medication and it took an hour before (name of CNA #2) told anyone. It was too close to regular time so I had to wait longer. R #87 was asked if she had told anyone about CNAs #1 and #2 she stated Yes I have told (name of LPN #1). (Name of LPN #1) knows that it is hard for me to write with my nerves. So I did not fill out a formal grievance report. K. On 09/26/14 at 11:50 am, LPN #1 was interviewed. LPN #1 was asked if they had been made aware of any issues that R #87 had with CNA #1 and CNA #2. The LPN stated, Yes, they have not brought (name of R #87) food or drinks sometimes; (name of R #87) told me that she thinks they believe she is more capable of doing things then she is. I talked to (name of CNA #1) and told them that (name of R #87) is a resident. We have to respect the residents. You have to answer (name of R #87)'s light, and assist (name of R #87) with all needs. They said they tried to encourage (name of R #87) to do more on the resident's own. When asked if the incident had been reported to administration, LPN #1 stated, I did not report this issue because I did not take it in a way that would suggest abuse. L. Review of the grievance log revealed no evidence of incident report concerning R #87, CNA #1 and CNA #2.
F 0241 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Provide care for residents in a way that keeps or builds each resident's dignity and respect of individuality.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and observation, the facility failed to ensure that staff were treating residents in a dignified manner that maintains and enhances the residents' self-esteem and self-worth for: a). 10 (R #34, 41, 42, 54, 76, 128, 131, 138, 141, and 251) residents of 10 (R#34, 41, 42, 54, 76, 128, 131, 138, 141 and 251) observed in the dining room during meals. The facility was placing clothing protectors on residents without asking permission and b). not providing meal service in a timely manner for 1 (#110) of 1 (#110) observed during the dining experience. This deficient practice has the potential to diminish the residents ability to dine in a dignified manner and in an atmosphere of respect. The findings are: A. On 09/23/14 at 11:40 am, during observation of the noon dining meal in room [ROOM NUMBER], CNA's (Certified Nursing Assistant) #'s 4 and #7 were observed placing clothing protectors on ten residents (R # 34, 41,42, 54, 76, 128, 131,138, 141, 251) without first asking the residents' approval. B. On 09/26/14 at 12:48 pm, during observation of the noon meal service six tables had one resident with a tray and the other three residents sitting at the table without drinks or food. Resident #110 was observed to leave the dining room without receiving his tray. Resident #110 stated, I am getting out of here. They never feed me anyway. No staff were observed re-directing Resident #110 or encouraging him to stay and eat a meal. Based on observation and interview the facility failed to promote dignity and self respect for 4 (R#40, 156, 249, and 253) of 4 (R#40,156, 249, and 253) residents sampled for dignity or self esteem. The failures included a) not answering call lights or positioning in a timely manner for Resident #156, b) not checking and changing incontinent residents in a timely manner for Resident #40 and Resident #253 and c) not providing coffee for resident #249 in a respectful and dignified manner. This failure to provide for a dignified treatment of [REDACTED]. The findings are: A. On 09/23/14 at 12:15 pm, during an interview, Resident #156 stated, They do not answer my call light at night. They are supposed to check me every 2 hours and they never do. I don't know when I'm going to have a bowel movement, but I know when I have a accident. I have layed in my diaper for over 2 hours, that is how I got the 'boil' on my butt. I was doing better, now I have to get better all over again. A couple of the nurses are mean and tell me to do it myself, they don't have time. My left shoulder is hurt and they are rough with the hoyer lift. It seems like they don't know how to use it. B. On 09/26/14 at 12:20 pm, during an interview, Resident #156 stated that he had been sitting in his wheelchair since 6:00 am that morning. The resident stated that he wanted to lay down after physical therapy at 10:00 am, but that staff told him he had to wait until 2:00 pm. Resident #156 stated that he was currently wet from urine and had not been changed since 6:00 am. C. On 09/23/14 at 4:32 pm, during a family interview, Resident #253's family member stated, They (staff) leave her wet when she (R #253) needs to be changed. I try to be here as often as I can so I can make sure she does not stay wet. She does not like to be wet and she feels bad when it happens. When the call light is on, no one comes to check. Yesterday, she needed to go to the bathroom. A male CNA came to check on her. He went to get the nurse, but she took forever to come and help. D. On 09/24/14 at 9:40 am, during a family interview for Resident #40, the family member stated, I do her laundry and there always clothing that is wet from accidents. I know that bothers her and she should be checked and changed more often. E. On 09/25/14 at 11:07 am, during an interview Resident #249 stated, I have issues with me getting coffee when I ask for it. They will tell me we're too busy or come back later when I go to get coffee. This happens at 6-6:30 am. I push the button at the Dietary door and they make me feel like a hobo begging for coffee. I am persistent, so I do get the coffee. It is only one Dietary Aide. I am not sure of her name. She was working this morning (09/25/14). F. On 09/26/14 9:34 am, during an interview the Dietary Manager (DM), the DM was asked how residents can get coffee in the morning. The DM stated, Residents get the coffee by usually sending the CNAs or sometimes they can ask themselves by ringing the doorbell. We put the coffee tray out at 6:00 am and (Name of CNA #6) is there at that time to monitor residents in the dining room. The DM was asked who answers the door, the DM stated, Anyone available will answer the door to take the residents request. The DM was asked if he had a dietary aide who would provide coffee service for R #249, the DM stated, Yes, (name of dietary aide #1) is a dietary aide. The DM was asked if Dietary Aide #1 answers the door, he stated, She answers the door if she is available. The DM was asked if he was aware of any issues with R #249 and Dietary Aide #1 he stated, No.
F 0242 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Make sure each resident has the right to have a choice over activities, their schedules and health care according to his or her interests, assessment, and plan of care.** Based on record review and interview the facility failed to provide bathing/showering assistance according to resident needs and preference for three (#40, 156, and 249) of three (#40, 156, and 249) residents sampled for choices. This deficient practice has the potential to cause residents discomfort from not receiving the showers they want. The findings are: A. On 09/24/14 at 9:35 am, during a family interview for Resident #40 the family member stated, My mom's shower days are Monday and Thursday in the morning. She doesn't always want a shower in the morning, she wants them in the afternoon. If they come in the morning and she doesn't feel good, she doesn't get a shower. 1. Review of the ADL flow sheet dated 08/2014 indicated Resident #40 received a bath four of the 31 days of the month.

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F 0242 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 3) 2. Review of the ADL flow sheet dated 09/2014 indicated Resident #40 received a bath five days of the 30 days of the month. B. On 09/23/14 at 12:47 pm, during an interview Resident #156 stated, I don't get showers because the shower chair is to small for me, so now they are trying to give me bed baths. I can't tell you the last time I had a bath. 1. Review of the Activities of Daily Living (ADL) flow sheet for Resident #156 dated 08/2014 indicated the resident received a bath three of the 31 days of the month. 2. Review of the ADL flow sheet for Resident #156 dated 09/2014 indicated the resident had not received a bath for the month of September. C. On 09/23/14 at 9:42 am, R #249 was asked if he chose how many times a week he took a shower, he responded No. I would like more showers. D. On 09/25/14 at 11:07 am interview with R #249 revealed, Tuesdays and Fridays 2-10 pm are my shower days. I told one of the staff members that I wanted more showers. I am not sure which one. They didn't tell me that I couldn't have more showers, they just indicated that it was those days. 1. On 09/23/14 at 11:07 am, observation of the resident's room revealed R #249's shower schedule was posted on the white board hanging on the resident's wall. The schedule stated Tuesdays and Fridays 2-10 pm. 2. Record review of the resident shower schedule at the nurse's station revealed that R #249's room was scheduled on Tuesdays and Fridays 2-10 pm. 3. Review of the ADL Flow Record revealed R #249's bathing records between 09/16/14 - 09/24/14 . R #249 had only been bathed once on 09/23/14. The bathing sheets for R #249 were not found. E. On 09/25/14 at 12:30 pm, the Assistant Director of Nursing (ADON) was interviewed. The ADON stated, Residents are bathed two times a week. If there is no paper work (referring to the missing shower sheet for R #249) it might be because we use agency staff and they sometimes do not do the paper work. 1. On 09/25/14 at 1:10 pm, the Acting Manager (AM) stated, The Angel Program report revealed that he refused a shower. He gives himself a sponge bath every day. He has only had one bath. 2. On 09/25/14 at 8:13 am, CNA #3 was interviewed. CNA #3 was asked what is the process when residents want to change their shower schedule. CNA #3 stated, If a resident wanted to change shower times, they tell us. We will let the nurses know. The nurses will tell the Staffing Coordinator (SC) and she changes the schedule. 3. On 09/25/14 at 8:15 am, LPN #2 was interviewed. LPN #2 was asked what the process was when the residents want to change their shower schedule. LPN # 2 stated, The resident will tell us. We make a note and give it to the SC. She will make the changes the residents shower schedule. 4. On 09/26/14 at 8:35 am, the SC was interviewed. The SC was asked what is the process when residents want to change their shower schedule. The stated, The nurses give me a note then I change the resident schedule. The SC was asked if she knew that R #249 wanted to change shower times. The SC stated They (no specific person was identified) said there was a little note saying he did want to change his showers, but I did not see it. It was on a sticky note in the back of the paperwork I picked up and I didn't see it till yesterday (09/25/14). The sticky note did not have a date or name. I do not know when he requested to change his showers or who made the note. I went to go talk to him yesterday to see what is going on. I told him I should have known before now if (name of R #249) wanted to change his shower.
F 0248 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide activities to meet the interests and needs of each resident.** Based on record review, interview, and observation the facility failed to provide activities to residents that were meaningful and meet the needs of the residents for three (#40, 218, and 253) of three (#40, 218, and 253) residents sampled for activities. This failure has the potential for residents not reaching or maintaining their highest psychosocial and physical well-being. The findings are: A. Observations of residents in activity programs indicated the following: 1. On 09/22/14 at 2:00 pm, 11 residents were sitting in their wheelchairs, lined up in a row, against a large window. Four residents were sitting in the television room, asleep in their wheelchairs, not watching the program on the television. 2. On 09/23/14 at 10:20 am, nine residents were sitting in their wheelchairs in the television room. The television was on, but residents were not actively watching. There was one staff member playing a checker game with one resident. 3. On 09/23/14 at 2:20 pm, five residents were sitting in the television room without staff interaction. 4. On 09/23/15 at 2:45 pm, eight residents were sitting in the television room with no activity occurring. 5. On 09/23/14 at 4:20 pm, 28 residents were lined up along the hall and sitting in the television room, with no activity occurring. 6. On 09/25/14 at 2:30 pm, 13 residents were sitting lined up in front of the hallway window and down the corridor with no activity occurring. 7. On 09/26/14 at 9:00 am, 25 residents were sitting in wheelchairs in the television room, lined up in the hallway, and at the nurse's station with no activity occurring. B. On 09/23/14 at 4:00 pm, during an interview, Resident #218 stated, There is nothing to do around here.what activities? Review of Resident #218's care plan dated 06/20/14 indicated Resident #218 had indicated he likes to hunt and fish. The care plan indicates activity staff will attempt one on one room visits because the resident refuses other activities. There was no documentation to indicate the facility had attempted to incorporate and develop activities that were meaningful for Resident #218. C. On 09/24/14 at 9:40 am, during a family interview for Resident #40 the family member stated, I feel my mother is depressed and there is no extra encouragement for her to attend activities. The facility really does need to work with her more. 1. Observations of Resident #40 during survey on 09/22/14, 09/23/14, 09/24/14,and 09/25/14 the resident was in bed and did not participate in activities. 2. Review of the care plan for Resident #40 dated 08/14 indicated the resident needed assist to and from activities. D. Review of facility resident council minutes dated 04/01/14-09/23/14 indicated the following request from residents regarding activities: 1. Residents want more outings and weekend entertainment. 2. Residents want to go to movies, the zoo, etc., but space on the facility van is limited and time is a consideration as the driver has medical appointments to take residents to. 3. Residents would like a Friday happy hour with music on the patio. 4. Movie day out of the facility. 5. More games and arts projects. E. On 09/26/14 at 5:30 pm, during an interview, the Activity Director stated she had been the Activity Director for approximately four months. She stated that she had recently been able to hire two additional staff and that would enable her to provide a variety of activities and to assist residents to attend those activities.
F 0252 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide a safe, clean, comfortable and homelike environment.** Based on observation and interview the facility failed to provide a environment that reflected the resident's personal choice and belongings for four (#110, 156, 218, and 251) of four (#110, 156, 218, and 251) resident rooms observed. This failure is likely to cause residents to be uncomfortable and unfamiliar with their rooms. The findings are: A. The following observations were made: 1. On 09/22/14 at 2:00 pm, Resident #110's room was observed. The resident was lying in bed. The resident had no blanket or comforter. The bulletin board above the resident's bed was bare. There was nothing on the bedside table or walls to indicate this was Resident #110's home. 2. On 09/22/14 at 2:10 pm Resident #156's room was observed. The resident was sitting up in his wheelchair. The resident's bed was bare except for sheets and there was nothing to indicate this space was the resident's home. On 09/22/14 at 2:11 pm, Resident #156 stated, They don't let you bring anything here.are you kidding.you are lucky to have a bed. 3. On 09/22/14 at 2:15 pm, the Room of Resident #218 was observed. The bedside table and bulletin board was bare. There was a faded blanket for a bedspread. On 09/22/14 at 2:17 pm, Resident #218 stated, I don't know what they let you bring in that

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ST THERESA HEALTHCARE AND REHABILITATION CENTER	7900 CONSTITUTION AVENUE NE ALBUQUERQUE, NM 87110

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F 0252 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 4) is mine. I don't have enough pants or shirts. I miss my home and pictures of my daughters. 4. On 09/22/14 at 2:30 pm, the room of Resident #251 was observed. The walls, table, and bed of this resident was bare. There was nothing to indicate this was the Resident's home. B. On 09/25/14 at 4:30 pm, during an interview, the Social Services Director (SSD) stated, I have only worked at the facility for about three months. The SSD stated, I am still learning the residents, but I am aware that residents should be encouraged to bring personal possessions to the facility and if the resident's were unable to, the facility should attempt to make the residents rooms more homelike.
F 0253 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide housekeeping and maintenance services.** Based on observation and interview the facility failed to maintain resident bedrooms in good repair for four room (#'s 23, 27, 29, and 30) of eight resident rooms observed (#'s 16, 23, 24, 26, 27, 29, 30, and 31). This failure has the potential to render resident rooms uncomfortable and unsafe. The findings are: A. On 09/23/14 at 10:00 am, observation of Room #23 indicated: 1. Long, scratch marks into the paint midway up the wall on four walls of the room. 2. The door to room #23 was scuffed with black mark along the front and back of the door. 3. The window blinds for the one window had two slats that were broken. 4. There was circular area of orange colored dried substance under the outlet on the wall to the right of the door. B. On 09/23/14 at 10:10 am, observation of Room #27 indicated black, scuff markings on the wall alongside the bathroom and under the window. C. On 09/23/14 at 10:15 am, observation of Room #29 indicated: 1. The bathroom door had deep, long splinters on the interior side of the door. 2. The metal door jam for the bathroom door had deep dents and scratches. 3. The grout for the lower half shower tiles was black. 4. There were feces on the toilet seat in the bathroom and the bathroom was malodorous. 5. The vent under the window was broken, with slats missing. 6. The wall next to the bathroom had a large square of wall paper that been cut out of the wall. 7. Baseboards for three side of the bedroom were loose and coming off. 8. The bumper board behind the residents' bed was dirty and the paint was peeling off. D. On 09/23/14 at 10:30 am, observation of Room #30 indicated: 1. The bumper board behind the resident's bed was falling away from the wall, being held up with two screws. There was also a hole in the wall behind the resident's bed. 2. A section of baseboard closest to the door to the room, was hanging off, exposing the sheet rock behind the baseboard. E. On 09/26/14 at 10:00 am, a tour of Room #'s 23, 27, 29, and 30 were made with the Maintenance Director and Housekeeping Supervisor to point out the identified issues. The Maintenance Director stated he was relatively new and was attempting to schedule issues as he found them so they could be repaired.
F 0254 **Level of harm** - Potential for minimal harm **Residents Affected** - Many	**Provide clean bed and bath linens that are in good condition.** Based on interview and observation the facility failed to provide washcloths and blankets in good condition for resident use for three (#'s 1, 2, and 3) of four (#'s 1, 2, 3, and 4) hallway clean linen carts observed. This failure has the potential for 96 residents residing in these hallways to not have the necessary items for bathing and sleeping. The findings are: A. During an interview with a family member of Resident #40 on 09/24/14 at 9:35 am, the family member stated, The bath towels and washcloths provided were thin and worn out. The family member stated, The blankets appeared old and in bad condition. The family member stated, I bought and brought comforters, washcloths, and towels to the facility and then laundered them myself so Resident #40 would have nice linen. B. On 09/26/14 at 11:00 am, observation was conducted of the clean linen carts indicated six blankets that were ripped and unraveling, and twelve wash cloths that were thin and unraveling. C. On 09/26/14 at 11:30 am, an interview was conducted with the Housekeeping Supervisor. The findings listed above, were acknowledged by the Housekeeping Supervisor.
F 0279 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Develop a complete care plan that meets all of a resident's needs, with timetables and actions that can be measured.** Based on record review and interview the facility failed to perform a fall risk assessment, after having two separate falls on two consecutive days, for one (R #248) of 3 (#119, 142, and 248) residents sampled for falls. This deficient practice had the potential to cause the resident prolonged pain and discomfort from not assessing the nature and extent of the falls. The findings are: A. On 09/24/14 at 9:35 am, Licensed Practical Nurse (LPN) #3 was asked had R #248 had a fall and/or sustained a fracture within the last 30 days, she stated, Yes, a fall on the 09/21/14 with no injuries. B. Review of the POS [REDACTED]. Situation, res (resident) found on the floor laying on her R (right) side by her bed. Assessment no injury marked. Additional Information, 22:30 I was called in the room by CNA (Certified Nurses Aid) res (resident) found laying on the floor on her R (right) side side (sic) by her bedside. She stated she was transferring herself from w/c (wheelchair) to bed, then she fell . 0 injury noted. C. Review of the POS [REDACTED]. Assessment no injury marked. Additional information, Resident was trying to transfer herself from the w/c (wheelchair) to the floor. Resident end (sic) up slipping out of her w/c (wheelchair) to the floor. Resident didn't hit her head. Denied any pain vitals stable resident already on neuro's. Notified MD, daughter (unreadable), on call person. Will cont. (continue) to monitor. D. Review of the residents care plan dated 09/18/14 revealed the following: 1. Impaired mobility Bed Mobility extensive assist is marked. Call light within easy reach (sic) encourage use. Assist with ADLs as necessary. 2. Transfer extensive assist is marked. 3. Locomotion on the unit extensive assist is marked. 4. Locomotion off the unit extensive assist is marked. 5. Toilet use extensive assist is marked. 6. Resident believes he/she is capable of increased independence. 7. Staff believe resident is capable of increased independence. 8. Dressing is marked extensive assist. 9. Urinary incontinence. No action indicated. 10. Date initiated 09/03/14 History of falls prior to admission is not checked. Falls since admission or prior assessment is not checked. E. On 09/25/14 at 8:15 am, an interview was conducted with the Director of Nursing (DON). The DON stated, Everyone puts their part in the care plan, so it would have different dates. If something was to happen then we put it in the care plan. If something was not necessary then we take it out. F. On 09/25/14 at 8:37 am, LPN #4, was asked if R #248 had fallen in the last 30 days, after review of the resident's chart, LPN #4 stated Yes, on 09/20/14. G. Review of the policy and procedures for Fall Management revised date 12/16/13 revealed the following: 1. The Care Plan will be updated to reflect current interventions. 2. A post fall review meeting will be completed by the IDT within 72 hours of the fall and additional care plan interventions implemented as indicated.

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F 0279 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 5) H. An interview with Director of Nursing DON on 09/25/14 at 10:55 am, revealed, No, there was no updated fall risk assessment done for R #248. I went to go see her because that was unusual that she had fallen. I noticed something different with Resident #248. She was coughing and I felt that she was congested. So I wanted her to see Physician Assistant (PA #1). So, I gave him the chart and I have not seen it since. He did agree with her being different. The fall happened over the weekend and so the review would have been on Monday. That did not happen. The fall risk assessment should have been done within the next day. I have not done that. The care plan should have been done as well.
F 0309 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**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 on record review and interview, the facility failed to coordinate services for one (Resident #251) of one (Resident #251) resident reviewed for hospice services. This failure had the potential to result in inaccurate medical treatment, decrease in quality of care and a decrease in quality of life. The findings are: A. Records review revealed Resident # 251 was admitted to the facility 08/25/14 on Hospice. Admission [DIAGNOSES REDACTED]. B. A review of the facility plan of care dated 08/25/14 revealed Resident # 251 was admitted on and is receiving hospice services. C. A review of Physicians Progress notes dated, 07/08/14, prior to Residents admission to facility, revealed .Resident's Hospice [DIAGNOSES REDACTED]. Review of the Hospice Care plan revealed, Responsible discipline for approaches needs are marked as to Hospice and/or nursing facility as well as Social services responsibilities. Initial Hospice certification is dated 07/08/14. Full Hospice documentation to include, Comprehensive assessment and plan of care, Hospice certification are present and up-to date. Hospice Nurses have visited the resident on 08/25, 08/29, 09/09, and 09/17 as evidenced by a sign-in page. D. On 09/25/14 at 9:30 am, an interview was conducted with the Director of Nursing (DON). When asked about the communication between Hospice and the facility the DON stated, The Hospice nurses let the Charge Nurse, Certified Medication Aid (CMA) and Certified Nursing Assistants (CNA) know they are here to visit the Resident. They verbally report and concerns, changes in medications or treatment. When asked if there is any written communication documenting the visit, concerns, changes to the care plans or medications the DON stated, The visit notes should be in the chart. A review of the Residents record with the DON revealed no evidence of any written communication between the facility and hospice or hospice to the facility on any hospice visits.
F 0311 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Make sure that residents receive treatment/services to not only continue, but improve the ability to care for themselves.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview the facility failed to give the appropriate services to maintain or improve the resident's abilities for 1 (R #253) of 2 (#40 and 253) residents sampled for Activities of Daily Living (ADL's). This deficient practice has the potential to cause the resident to lose the ability for the highest practicable outcome. The findings are: A. On 09/23/14 at 4:32 pm, a family member of R #253 was interviewed. (Name of family member) stated, They (staff) leave her wet when (Name of R #253) needs to be changed. I try to be here as often as I can so I can make sure R #253 does not stay wet. R #253 really does not like to be wet. (Name of R#253) feels bad when it happens. When the call light is on, no one comes to check. Yesterday a male CNA came to check on R #253. R#253 needed to go to the restroom. He (CNA) went to get the nurse but she took forever to come and help. B. Review of the Nursing Admission and assessment dated [DATE] revealed Elimination Bladder Habits continent is marked. Bowel Habits continent is marked. C. Review of the Assessment for bowel and bladder dated 09/17/14 Bladder History incontinent and continent are both marked. CNA walk to bathroom or transfer to toilet/commode, can manage clothing, wipe, etc, needs assistance from one side. Mentally aware of toileting needs, yes always. D. Review of the ADL flow sheet revealed the following: 1. Toilet use from 09/18/14 at night through the 09/24/14 is marked as extensive assistance. Day is marked as both limited and extensive assistance. Evening is marked as both limited and extensive assistance. 2. Bladder function incontinent at night and continent day and evening. 3. Bowel function incontinent and continent during the night and continent during the day. E. On 09/26/14 at 10:40 am, Licensed Practical Nurse (LPN #2) confirmed the incontinence of R #253 at night and that she came into the facility continent. F. On 09/26/14 at 10:48 am, an interview was conducted with the Assistant Director of Nursing (ADON). The ADON stated that R #253 was not on the bowel bladder program. G. On 09/26/14 at 12:35 pm, an interview with R #253's family member revealed (Name of R #253) was wet yesterday (09/26/14) and she was sad. She does not like being wet, but she has kidney disease so she can't hold that long. I told her if she has to wait a long time for the staff, go ahead and go (in her incontinence briefs), it is not good to hold it.
F 0354 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Use a registered nurse at least 8 hours a day, 7 days a week.** Based on record review and interview, the facility failed to provide the services of a Registered Nurse (RN) for at least 8 consecutive hours a day, seven days a week for a period of 1 day from June 1 through June 30, 2014; 3 days from July 1 through 31 July, 2014 and 1 day from August 1 to August 30, 2014. The failure to have a Registered Nurse on duty on a daily basis would likely affect the residents mental and physical health, and affect their highest practicable quality of care. The findings are: A. A review of the Nurse's June 2014 schedule revealed there was no Registered Nurse coverage on 06/21/14. B. A review of the Nurse's July 2014 schedule revealed there was no Registered Nurse coverage for 07/14/14, 07/20/14 and 07/21/14. C. A review of the Nurse's August 2014 schedule revealed there was no Registered Nurse coverage for 08/17/14. D. On 09/26/14 at 3:50 pm, an interview was conducted with the DON. When asked about there being a RN working the units on, 06/21/14, 07/14/14, 07/20/14, 07/21/14 and 08/17/14 the DON stated, According to our staffing sheets and the Daily Nursing Staff Posting there was no RN on duty for those dates.
F 0364 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Prepare food that is nutritional, appetizing, tasty, attractive, well-cooked, and at the right temperature.** Based on interview, the facility failed to provide food that is palatable and that is served at the proper temperature for five (#31, 40, 176, 218, and 249) of five (#31, 40, 176, 218, and 249) residents sampled for dining. This deficient practice has the potential for residents to receive food that is not palatable and not served at proper temperature. The findings are: A. On 09/23/14 at 9:33 am, during an interview R #31 was asked how the food tastes and is the food at the proper temperature. R #31 stated, The food is ok, but it is sometimes cold. R #31 was asked if the food is cold for any specific meal, R #31 stated, Lunch and dinner are usually cold. B. On 09/23/14 at 10:30 am, during an interview, R #176 was asked how the food tastes and is the food at the proper temperature, R #176 stated, The food is cold. I have to send it back to be reheated. R #176 was asked if the food was cold for any specific meal, R #176 responded, It is mainly lunch and dinner. C. On 09/23/14 at 10:30 am, during an interview R #40 was asked how the food tastes and is the food at the proper temperature, R #40 stated, The dinner and the lunch are bad. I don't like the meals.

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F 0364 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 6) D. On 09/24/14 at 10:14 am, during an interview Resident #218 stated, The food does not taste good. The eggs and meat are cold. There is never enough food, I am always hungry. E. On 09/24/14 at 11:50 am, during an interview R #249 was asked how the food tastes and is the food at the proper temperature, R #249 stated, The food is cold some times. The food that should be warm is cold. F. Review of the Resident Council meeting minutes dated 04/01/14-09/23/14 indicated residents complained that cooked vegetables were mushy, meats were tough and hard to chew, and there was not enough bacon or sausage for breakfast. G. On 09/26/14 at 1:10 pm, a test tray for the lunch meal was provided. The following was indicated the baked fish was over-cooked and was cold. The rice tasted bland and the mixed vegetables were cold. H. On 09/26/14 at 3:00 pm, during an interview the Consultant Registered Dietician (RD) stated, I am surprised to hear about the resident's concerns regarding food temperature and palatable meals.
F 0412 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide or obtain dental services for each resident.** Based on record review, interview and observation, the facility failed to refer one (#40) of one (#40) residents sampled for dental status and services to a dentist after her dentures became loose and did not fit well. Improper fitting dentures has the potential to harm residents using them because the resident cannot eat well. The findings are: A. On 09/24/14 at 9:40 am during an interview, a family member of Resident #40 stated that the Resident's dentures did not fit well and were loose. The family member stated that she wondered if the loose dentures kept Resident #40 from eating well. B. Observation of Resident #40 on 09/24/14 at 12:15 pm, indicated the resident was lying in bed and had her meal tray in front of her. The resident's dentures were laying next to the water pitcher on the bedside table. C. Observation of Resident #40 on 09/25/14 at 11:50 am, indicated the resident was eating lunch and her dentures were on the bedside table. C. Review of Resident #40's care plan dated 11/22/13 and updated 08/2014 indicated no documentation that the resident had dentures or how they fit. D. On 09/25/13 at 10:00 am, during an interview the Social Services Director (SSD) stated that she was unaware of the denture issues regarding Resident #40. The SSD stated that she would make an appointment with the dentist as soon as possible.
F 0463 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Make sure that a working call system is available in each resident's room or bathroom and bathing area.** Based on observation and interview, the facility failed to maintain the call light system in good repair for one (# 254) of one (#254) residents reviewed for a functioning call light system. The failure of a call light system to operate has the potential to harm residents needing assistance from staff and staff being unaware the residents need assistance. The findings are: A. During room observations on 09/23/14 at 3:45 pm, indicated Resident #254 would push the call light and it would not work. B. On 09/24/14 at 7:53 am, observation of Resident #254, indicated the call light would not light up when the call button was pushed. B. On 09/26/14 at 1:15 pm, the Maintenance Director was taken to Resident #254's room. He pushed the call light button and it did not work. He stated he would have to get a new unit and replace the current one.
F 0464 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide at least one room set aside to use as a resident dining room and for activities, that is a good size, with good lighting, air flow and furniture.** Based on observation and interview, the facility failed to provide sufficient space for 17 Residents (R #34, 41, 42, 44, 54, 60, 71, 76, 118, 120, 124, 128, 131, 138, 141, 154, and 251) out of 17 Residents (R #34, 41, 42, 44, 54, 60, 71, 76, 118, 120, 124, 128, 131, 138, 141, 154, and 251) who eat in room 25. This deficient practice resulted in residents have to wait to eat while other residents are eating. This failure to provide adequate space for dining had the potential to not provide the appropriate environment for residents to enjoy the meal experience. The findings are: A. On 09/22/14 at 5:00 pm, CNA #4 was interviewed. CNA #4 was asked if 2 groups of residents eat in shifts in room 25. CNA #4 stated that Room 25 is for residents who need extra assistance with meals and there is not enough space for all of the residents to eat at one time. B. On 09/23/14 at 11:45 am, observation of nursing station revealed 5 residents waiting to get into Room 25 to eat. C. On 09/23/14 at 11:50 am, CNA #5 was interviewed. CNA #5 was asked if the residents around the nurse's station were waiting to go into Room 25. CNA #5 stated, Yes. They usually wait here. D. On 09/23/14 at 12:30 pm, observation indicated 11 residents waiting around the nurse's station to go into Room #25 to eat, including Resident #138. Resident #138 repeatedly stated to staff walking past her, I need help, I need to eat. E. On 09/24/14 at 12:09 pm, observation of nurse's station revealed 7 residents were waiting around the nursing station to get into Room 25 to eat. F. On 09/25/14 at 11:45 am, Resident #138 was observed sitting across from the nurse's station waiting to go into Room #25 to eat lunch G. On 09/25/14 at 11:50 am, observation of the area in front of the nurse's station next to Room 25 revealed 6 residents waiting for the second dining shift in Room 25. H. On 09/26/14 at 4:51 pm, the Director of Nursing (DON) was interviewed. The DON stated, The residents that could not tolerate the larger dining room and anyone who needs help are put in room 25. The residents in Room 25 do not do well in the large dining room. Many have improved eating while they were in there (Room 25). I didn't know they were lined up outside Room 25. The residents in the dining room have to wait to get their food, so I am not sure what the problem is if they wait there. It is a process to feed that many residents. We could not put those residents (residents from room 25) in the dining room. The residents would not all fit in the dining room. I. On 09/26/14 at 5:39 pm, the Activities Director (AD) was interviewed. The AD was asked why so many residents were lined up sitting in wheelchairs near the door of Room 25 at the nurse's station. The AD stated, The residents are lined up out there in front of the nurse's station waiting to get into Room 25 to eat.
F 0491 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	**Be licensed under State and local laws.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview the facility failed to maintain a current State of New Mexico Operators license as required. This failure is likely to harm the 116 residents living in the facility based on the Resident Census Listing provided by the facility acting manager on [DATE] at 1:15 pm. An unlicensed facility cannot be certified, with a potential for the residents to be displaced. The findings are: A. On [DATE] at 1:15 pm, upon entrance to the facility, it was observed that the required Operator's license issued by the State of New Mexico had expired as of [DATE]. B. On [DATE] at 4:30 pm, the Corporate Registered Nurse, and the acting person in charge stated that they would begin looking for a renewal application for licensure. C. On [DATE] at 5:30 pm, during the exit conference, the Administrator acknowledged the facility was not currently licensed.
F 0493 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	**1) Set up a group that is legally responsible for writing and setting up policies for leading and running the nursing home; or 2) hire a properly licensed administrator.**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	325042	A. BUILDING _____ B. WING _____	**10/01/2014**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ST THERESA HEALTHCARE AND REHABILITATION CENTER	**7900 CONSTITUTION AVENUE NE ALBUQUERQUE, NM 87110**

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 0493 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Many	(continued... from page 7) **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview the facility governing body failed to name a licensed Administrator for the facility. This failure has the potential to harm the 116 residents on the Resident Census listing provided by the Acting Manager on 1:15 pm on [DATE], because without an Administrator the facility cannot ensure services are provided effectively. The findings are: A. Upon entering the facility on [DATE] the State of New Mexico Operator's License was observed. The license had expired [DATE] and had the name of Administrator #1 listed as the Administrator. B. Review of facility documents indicated that Administrator #1 was no longer the administrator and had not worked at the facility as of [DATE]. C. On [DATE] at 3:30 pm, the acting Manager stated an Administrator at another facility was the Executive Director and oversaw this facility as an Administrator. D. On [DATE] at 9:30 am, the acting Manager produced a letter dated [DATE] that named Administrator #2 as the administrator effective [DATE] after the survey had begun at the facility.