STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	325086	A. BUILDING _____ B. WING _____	09/12/2018

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
CASA MARIA HEALTHCARE CENTER AND PECOS VALLEY REHA	1601 SOUTH MAIN STREET ROSWELL, NM 88203

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 0656 **Level of harm -** Actual harm **Residents Affected -** Few	**Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** > Based on interview, observation and record review the facility failed to ensure that a comprehensive care plan for a gastrostomy tube (medical procedure in which a tube (G tube) is passed into a patient's stomach through the abdominal wall, for a means of feeding) and [MEDICAL CONDITION] (a surgical procedure in which an opening (stoma) is formed by drawing the healthy end of the large intestine or colon through an incision in the anterior abdominal wall for stool to pass through) was developed for 1 (R #3) of 4 (R #1, #2, #3 and #4) residents reviewed for care plans. If the resident's care plan does not accurately reflect the resident's health status, treatment and interventions, residents may not get the care and treatment that they need. The findings are: A. On 09/04/18 at 4:10 pm, during an interview, R #3's Family Member #1 (FM) stated that (Name of Resident #3) was so sick and was sent to the hospital from a physician's office (Physician #1) visit on 06/13/18. FM #1 further stated that (Name of Resident #3) was admitted to the hospital intensive care unit on 06/13/18 and had his/her colon removed due to a toxic mega colon (swelling and inflammation spread into the deeper layers of your colon, the colon stops working and widens and may rupture) and required a [MEDICAL CONDITION]. FM #1 stated that his/her colon was the size of a softball, and (Name of Resident #3) needed a feeding tube. B. On 09/04/18 at 4:10 pm, during an observation, R #3 had a gastrostomy tube to the upper left abdomen, a [MEDICAL CONDITION] to right mid abdomen, and a dry dressing was noted to the left [MEDICAL CONDITION]. C. Record review of the face sheet dated 05/24/18 for R #3 revealed, an admission of date of 05/24/18. R #3 had a re-admitted [DATE] and a third admission date of [DATE]. [DIAGNOSES REDACTED]. Difficile (Infection of the large intestine (colon) caused by the bacteria [MEDICAL CONDITION]) - Resolved, leukocytosis (white cells above the normal range in the blood), and chronic [MEDICAL CONDITION] (irregular and often fast heartbeat), with long-term anticoagulant (medication to thin the blood) use, diarrhea (liquid stools), toxic mega colon, status [REDACTED].), and [MEDICAL CONDITION] (high potassium). D. Record review of the only care plan dated 05/29/18 for R #3 revealed, there was no care plan for a re-admission on 06/28/18 for the care of R #3's [MEDICAL CONDITION] and gastrostomy tube. E. On 09/06/18 at 4:25 pm, during an interview, the Director of Nursing stated that there was nothing on the care plan for (Name of Resident #3's) [MEDICAL CONDITION] care, or feeding tube care.
F 0657 **Level of harm -** Actual harm **Residents Affected -** Few	**Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** > Based on interview, observation and record review the facility failed to ensure the comprehensive care plan was revised for severe weight loss for 1 (R #3) of 4 (R #1, #2, #3 and #4) residents reviewed for care plans. If the resident's care plan does not accurately reflect the resident's health status, treatment and intervention, residents may not get the care and treatment that they need. The findings are: A. On 09/04/18 at 4:10 pm, during an interview, R #3's Family Member #1 (FM) stated that (Name of Resident #3) was so sick and was sent to the hospital from a physician's office (Physician #1) visit on 06/13/18 and was admitted to the intensive care unit. R #3 had to have his/her colon removed due to a toxic mega colon (swelling and inflammation spread into the deeper layers of your colon, the colon stops working and widens and may rupture) and required a [MEDICAL CONDITION] (surgical procedure in which an opening (stoma) is formed by drawing the healthy end of the large intestine or colon through an incision in the anterior abdominal wall). FM #1 stated that his/her colon was the size of a softball, and (Name of Resident #3) needed a feeding tube (gastrostomy ([DEVICE]) - tube inserted in the stomach for nutrition). FM #1 stated that she told the Administrator, unknown date, and the Administrator was going to make sure it didn't happen again. R #3 was in the hospital from 06/13/18 through 06/28/18. B. On 09/04/18 at 4:10 pm, during an observation, R #3 had a gastrostomy tube to the upper left abdomen, a [MEDICAL CONDITION] to right mid abdomen, and a dry dressing was noted to the left [MEDICAL CONDITION]. C. Record review of the face sheet dated 05/24/18 for R #3 revealed, an admission of date of 05/24/18. R #3 had a re-admitted [DATE] and a third admission date of [DATE]. [DIAGNOSES REDACTED]. Difficile (Infection of the large intestine (colon) caused by the bacteria [MEDICAL CONDITION]) - Resolved, leukocytosis (white cells above the normal range in the blood), and chronic [MEDICAL CONDITION] (irregular and often faster heartbeat), with long-term anticoagulant (medication to thin the blood) use, diarrhea (liquid stools), toxic mega colon, status [REDACTED].), and [MEDICAL CONDITION] (high potassium). D. Record review of the care plan dated 05/24/18 for R #3 revealed, 06/12/18 - Category: Falls, at risk for falling related to below knee amputation and [MEDICAL CONDITION]. There is no interventions on the care plan for the [MEDICAL CONDITION] listed. E. Record review of a Data Collection/Evaluation Nutritional document dated 06/07/18 for R #3 revealed, Current weight 187 pounds, ideal body weight range 154-189, body mass index (BMI) 25.8. Caloric needs: 2550 per day, Protein needs: 127 grams per day and fluid needs: 2550 milliliters per day. F. Record review of vitals report for weight from admission date of [DATE] through 06/13/18 revealed: 1. 05/25/18 - 201.4 2. 05/26/18 - 197.2 3. 05/27/18 - 197.8 4. 05/30/18 - 188.8 This is a 13 pound loss, no interventions noted. 5. 06/06/18 - 178.6 This is a 23 pound loss. Recommended 1 ounce liquid protein every day. 6. 06/13/18 - 179.4 R #3 was discharged to the hospital. G. Record review of the vitals report for meal intake from 05/24/18 through 06/13/18 for R #3 revealed, 1. No amount of meal intake was documented for 05/27/18, 05/28/17, 05/29/18, 06/04/18, 06/07/18, 06/08/18, and 06/10/18. 2. Meal intake of 26-50% was documented for 06/09/18 and 06/13/18 with one refusal to eat on 06/09/18. H. Record review of the only care plan dated 05/29/18 for R #3 revealed, 05/29/18 - Category: Nutritional Status. No interventions were listed for the weight loss from 05/27/18 through 06/13/18, on the care plan.

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0657 **Level of harm** - Actual harm **Residents Affected** - Few	(continued... from page 1) I. On 09/06/18 at 4:25 pm, during an interview, the Director of Nursing (DON) stated that there was nothing on the care plan for (Name of Resident) for his/her weight loss. The DON further stated that the [MEDICAL CONDITION] infection was listed under falls as a reason for weakness but did have any interventions listed for the weight loss.
F 0690 **Level of harm** - Actual harm **Residents Affected** - Few	**Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** > Based on record review and interview the facility failed to provide treatment for 1 (R #3) of 1 (R #1) Resident with a history of [MEDICAL CONDITION] (C Diff) (infection of the large intestine (colon) caused by the bacteria of[DIAGNOSES REDACTED]), and repeated diarrhea. This deficient practice likely resulted in harm for R #3, by developing a toxic mega colon (swelling and inflammation spread into the deeper layers of the colon, the colon stops working and widens and may rupture), and the need for a [MEDICAL CONDITION] (a (stoma) constructed by bringing the end or loop of intestine out onto the surface of the skin, waste passes out of the [MEDICAL CONDITION] opening). The findings are: A. On 09/04/18 at 4:10 pm, during an interview, R #3's Family Member #1 (FM) stated that (Name of Resident #3) was so sick and was sent to the hospital from a physician's office (Physician #1) visit on 06/13/18. FM #1 further stated that (Name of Resident #3) was admitted to the hospital and had his/she colon removed due to a toxic mega colon and required a [MEDICAL CONDITION]. FM #1 stated that (Name of resident #3's) colon was the size of a softball. FM #1 stated that she told the Administrator, unknown date, and the Administrator was going to make sure it didn't happen again. R #3 was in the hospital from 06/13/18 through 06/28/18. B. Record review of Daily Skilled Nurses's Note for R #3 dated 06/13/18 for the day shift revealed, . 3:45 pm - Was notified by emergency room (ER) that (Name of Resident #3) was sent from the physicians office to ER. C. Record review of a office visit note for R #3 dated 06/13/18 from Physician #1 revealed, Reason for visit follow-up, extremity weakness, [MEDICAL CONDITIONS] (potentially life-threatening infection caused by a type of bacteria. It can cause [MEDICAL CONDITION], a serious inflammation of the colon), Vitals: Blood Pressure (B/P) 86/29 (normal 120/80) Pulse 101 (High- normal is 80) . D. Record review of bowel movement (BM) documentation by the Certified Nurse Aides (CNA's) for R #3 revealed, R #3 had loose stools (BM/diarrhea) on: 1. 06/01/18 10:13 pm - Loose 2. 06/03/18 at 10:30 am - Liquid 3. 06/05/18 at 2:27 am - Liquid 4. 06/05/18 at 8:35 am - Liquid 5. 06/09/18 at 11:13 am - Liquid 6. 06/10/18 at 1:21 am - Liquid 7. 06/10/18 at 3:21 am - Liquid 8. 06/10/18 at 4:29 am - Liquid 9. 06/10/18 at 5:09 am - Liquid 10. 06/11/18 at 2:39 am - Liquid 11. 06/11/18 at 6:03 am - Liquid 12. 06/12/18 at 1:13 am - Liquid 13. 06/12/18 at 6:02 am - Liquid E. Record review of Nurse's notes dated: 1. 06/ 06/18 no time documented revealed, diarrhea was checked on the day and night shift. 2. 06/ 07/18 no time documented revealed, diarrhea was checked on the day and night shift. 3. 06/ 08/18 no time documented revealed, diarrhea was checked on the day and night shift. 4. 06/10/18 no time documented revealed, diarrhea was checked on the day shift. 5. 06/11/18 no time documented revealed, diarrhea was checked on the day and night shift. There is no documented evidence that the physician was notified that R #3 was having loose, liquid bowel movements or diarrhea. F. Record review of a discharge summary from hospital #1 dated 06/28/18 for R #3 revealed, Came to the hospital due to diarrhea for weeks and had a toxic mega colon. He was told as an outpatient that he had a [DIAGNOSES REDACTED] infection. (Name of Resident #3) required a colectomy (Colectomy is bowel resection of the large bowel, the surgical removal of any extent of the colon) with [MEDICAL CONDITION] and gastrostomy ([DEVICE] - is a tube inserted through the abdomen that delivers nutrition directly to the stomach). G. Record review of a discharge summary from hospital #1 dated 06/28/18 for R #3 revealed, Date of admission: 06/13/18, Date of discharge: 06/28/18, Admission Diagnosis: [REDACTED]. Symptoms include abnormal heart rate, increased body temperature, decreased platelet count and inflammation throughout the body. People with [MEDICAL CONDITION] require close monitoring and treatment in a hospital intensive care unit and proper medications), diarrhea (loose bowel movements), [DIAGNOSES REDACTED] (low potassium), [MEDICAL CONDITION] (insufficient numbers of red blood cells). H. Record review of a discharge summary from hospital #1 dated 06/28/18 for R #3 revealed, Discharge Diagnosis: [REDACTED]. I. On 09/06/18 at 4:37 pm, during an interview, the Director of Nursing (DON) stated that she/he was not sure if the diarrhea had been reported sooner to R #3's Physician (#1) if the toxic mega colon could have been prevented. Physician #1 was called on 09/11/18 at 1:41 pm, a message was left for a return call. Physician #1 did not return the call.
F 0692 **Level of harm** - Actual harm **Residents Affected** - Few	**Provide enough food/fluids to maintain a resident's health.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** > Based on record review, and interview, the facility failed to maintain a resident's usual body weight for 1 (R #3) of 2 (R #1 and #3) sampled residents for weight loss. R #3 lost 22 pounds between 05/25/2018 and 06/13/18. This would be a severe weight loss percentage of 10.94%. (Center for Medicare and Medicaid (CMS)) considers a weight loss of greater then 5% in one month to be severe weight loss.) R #3 required the placement of a gastrostomy tube (also called a [DEVICE] - is a tube inserted through the abdomen that delivers nutrition directly to the stomach) on 06/14/18. The findings are: A. On 09/04/18 at 4:10 pm, during an interview, R #3's Family Member #1 (FM) stated that (Name of Resident #3) was so sick and was sent to the hospital on [DATE] from a physician's office (Physician #1). FM #1 further stated that (Name of Resident #3) was admitted to the hospital and had his/she colon removed due to a toxic mega colon (swelling and inflammation spread into the deeper layers of your colon, the colon stops working and widens and may rupture) and required a [MEDICAL CONDITION] (bowel resection of the large bowel, the surgical removal of any extent of the colon). FM #1 stated that (Name of Resident #3) required a feeding tube. B. Record review of a Data Collection/Evaluation Nutritional document dated 06/07/18 for R #3 revealed, Section 1 completed by the Dietary Manager (DM) Current weight 187 pounds, ideal body weight range 154-189,body mass index (BMI) 25.8. Section IV - Evaluation of Nutritional needs (to be completed by a registered Dietitian/Registered Diet tech) Caloric needs: 2550 per day, Protein needs: 127 grams per day and fluid needs: 2550 milliliters per day. Nutrition Intervention: Weight loss related to fluid loss. This section was completed by the facility's Dietitian. C. On 09/12/18 at 4:05 pm, during an interview, the Director of Nursing (DON), stated that she/he was not sure what the Dietitian was referring to in the note stating weight loss related to fluid loss. The DON could not find any documentation about [MEDICAL CONDITION] (ankles and/or feet are swollen due to accumulation of fluid), or fluid overload in the medical record. D. Record review of the vitals report for weight from admission date of [DATE] through 06/13/18 revealed: 1. 05/25/18 - 201.4 2. 05/26/18 - 197.2 3. 05/27/18 - 197.8 4. 05/30/18 - 188.8 This is a 13 pound loss, no interventions noted. 5. 06/06/18 - 178.6 This is a 23 pound loss.

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F 0692 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 2) 6. 06/13/18 - 179.4 R #3 was discharged to the hospital. E. Record review of a care plan dated 05/29/18 for R #3 revealed, Nutritional Status: Resident at risk for potential weight fluctuations. Resident will remain or progress to a healthy weight through the next review. Approach: 1. Provide diet as ordered with resident food preferences as feasible. 2. Encourage fluid intake, provide water pitcher at bedside unless contraindicated. 3. Monitor and encourage intake of meals - offer alternative if less than 50% of meal is consumed, 4. Offer snacks as ordered. Provide assistance with meals, snacks as necessary. F. Record review of the vitals report for meal intake from 05/24/18 through 06/13/18 for R #3 revealed, 1. No amount of meal intake was documented for 05/27/18, 05/28/17, 05/29/18, 06/04/18, 06/07/18, 06/08/18, and 06/10/18. 2. Meal intake of 26-50% was documented for 06/09/18 and 06/13/18 with one refusal to eat on 06/09/18. G. The care plan was not updated on return to the facility on [DATE] for the use of a gastrostomy (artificial external opening into the stomach for nutritional support) tube. H. On 09/06/18 at 3:20 pm, during an interview, the DM stated that the only thing the he/she is responsible for is the likes and dislikes list, the Dietician does everything else. The DM stated I cannot not make them (residents) eat, I provide their diets and they choose what they want. We have super cereal but if they don't want it they don't have to eat it. I. On 09/12/18 at 4:05 pm, during an interview, the DON stated that (Name of Resident #3) was not on a planned weight loss and initially lost weight.