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 _____	09/02/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
UPTOWN 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.

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F 0585 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances.** Based on interview and record review, the facility failed to ensure that residents were provided a written response regarding the outcome of their grievances. This deficient practice is likely to affect all 85 residents identified on the census provided by the Interim Administrator on 08/24/20. If the facility does not track grievances received and provide outcomes/response to residents, then the residents grievances are likely to be unresolved causing the residents frustration and depression. The findings are: A. Record review of the facility's Grievance Logs dated April 2020 through July 2020, revealed there were no grievances on file. Findings related to R #59: B. On 08/24/20 at 9:22 am, during an interview, R #59 stated the food is not edible in her opinion and she is spending a lot of money ordering snacks online to get her by. She stated the food is cold and just tasteless for all meals. She stated she normally would file grievances, but for a while they were not doing grievances. She stated she had written some complaints that were taken to the Dietary Manager about the food and never received a follow up. Findings related to R #10: C. On 08/24/20 at 1:16 pm, during an interview, R #10 stated he has had a really hard time requesting the food that he prefers, and he stated they (dietary staff) tell him they are out of eggs or send him scrambled eggs hoping he won't recognize the difference. He stated he has had no way to file a grievance until recently, because they were not doing them. He stated the staff would write his complaints down about the food and never return with a follow up. He stated at one time he showed Unit Manager #2 the eggs he received, and she said that looked terrible as well and she sent them back to the kitchen. D. On 08/26/20 at 10:38 am, during an interview, the Activities Director stated that she had no documentation of grievances brought to her and the facility was not filing grievances when COVID-19 hit the building, and stated Social Services was responsible for filing and resolving grievances. E. On 08/26/20 at 3:46 pm, during an interview, the Interim Administrator stated they will be going room to room to follow up on any grievances filed from April 2020 through July 2020 that were missed or not addressed and catch up on them as soon as possible. Stated she could not find any grievance documentation prior to her coming to this facility which was 08/21/20. F. On 09/01/20 at 9:47 am, during an interview, the Social Services Director (SSD) stated during the quarantine, grievances were not filed due to everything just being handled verbally and stated there was a lot of craziness going on. He stated the things he handled did not seem like a grievance, but rather more of a concern. The SSD confirmed there were no concerns or grievances in writing. G. Record review of the facility's grievance policy, last revision dated 08/18/20, revealed the following; .The residents have the right to: obtain a written decision regarding his/her grievance:
F 0656 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**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 record review and interview the facility failed to ensure that comprehensive person-centered care plans were developed for 9 (R #s 10, 16, 25, 29, 47, 68, 70, 71, and 75) of 10 (R #s 10, 13, 16, 25, 29, 47, 68, 70, 71, and 75) residents reviewed for range of motion, restorative services (a type of care a resident receives to improve or maintain physical function), and activities. These deficient practices would likely result in inconsistent delivery of interventions to residents with specialized care needs, resulting in a decline in activities of daily living, range of motion; and did not include activities in the care plan causing them to feel isolated and bored. The findings are: A. On 08/26/20 at 9:54 am, during an interview with the Activities Director (AD), she stated that she became the AD pretty much at the beginning of the Pandemic. She stated that the building was hit very hard and she also became sick with COVID and was out for about one month. She stated that she currently has one assistant and they are down one assistant. They do go around to the residents to ask them what they might like, a book, painting, coloring, etc. She stated that some residents are interested and some of them are not. B. On 08/31/20 at 8:45 am, during a follow up interview with the AD, she stated that she was not aware that she needed to put a care plan in place for new residents around activities and acknowledged that care plans were not in place for R #16, 29 and 75. C. On 08/31/20 at 9:39 am, during an interview with Certified Nursing Assistant (CNA) #2 she stated that she works on 300 hall, she stated that she does remember the brace for R #25, but she doesn't know what happened to it. D. On 08/31/20 at 9:54 am, during an interview the Director of Rehabilitation, she stated that they have tried to work with R #25. This is the second time they have tried to work with her because she has been referred to restorative a couple of times. She was given a splint/carrot (relieves pressure of severely contracted hands and prevents excessive moisture, pressure and the risk of puncture marks from the nails) for that hand, and she does see the order for this. She stated that this order is not discontinued. She stated that it looks like the CNA's should be putting it on R #25's hand daily. She also stated that R #25 does not like to be touched so it might be challenging. E. Record review of the physician's orders [REDACTED].#25, indicated the following: Occupational Therapy (OT) clarification orders: Orders received, and evaluation completed. Pt (patient) will not benefit from skilled therapy services at this time due to poor tolerance for touch and stretches to RUE (right upper extremity). Recommend carrot (brace device to assist with contractors) for R (right) hand at this time for contracture (permanent shortening of a joint) management and to reduce pain as well as prevent skin breakdown of the R (right) palm. F. Record review of the care plan for R #25 indicated that the brace and contracture were never care planned. G. Record review of R #'s 16 care plan dated 12/19/20, R #75 care plan dated 06/20/20, and R #29's care plan dated 06/20/20 indicated that all three were not care planned for activities. Findings for R #68: H. Record review of physician orders [REDACTED]. back position), including knee flexion/extension, hip abduction/adduction (abduction is the movement laterally away from the midline of the body, while adduction is to move toward the body or across the midline), ankle pumps 10 reps times three, as well as bilateral hamstring stretching for 30 secs times three. Pt (patient) to be seen for standing with FWW (front wheeled walker) for 10 secs times three with max assist. I. Record review of the care plan for R# 68, revealed that the care plan was not updated with documentation of restoratives services or goals. Findings for R #71: J. Record review of physician orders [REDACTED]. all 2x15 (2 repetitions of 15). K. Record review of the care plan for R #71, revealed that the care plan was not updated with documentation of restoratives services or goals. Findings for R #47: L. Record review of physician orders [REDACTED]. the body), hip internal external rotation, knee flexion/extension, ankle pumps 10 reps each, AROM (Active Range of Motion) right LE including hip abd/add (abduction/adduction), knee flexion/extension, ankle pumps 10 reps each. M. Record review of the care plan for R #47, revealed that the care plan was not updated with documentation of restoratives services or goals. N. On 09/02/20 at 10:29 am, during an interview with Registered Nurse (RN) #2, when asked to explain the process of how

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 0656 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 1) care plans get updated and when restorative services would be added, RN #2 stated We update the care plan on admission, quarterly, annual, and with any significant change, we follow the MDS (Minimum Data Set) schedule and we care plan for whatever the MDS triggers. Everyone is responsible for their section. Therapy does not care plan. Nursing will print the therapy recommendations as nurse orders and put it in the TAR. The nurse should care plan it. If we see documentation of the restorative services, we will care plan for it. If we do not see documentation, we cannot care plan it or add it to the MDS. The CNA's should document the restorative services on the TAR. When I do the MDS, the documentation of restorative services should then be updated on the MDS. When that service is added to the MDS, the facility would receive a higher pay rate for that higher level of care. O. Record review of the facility's Restorative Nursing Guidelines, dated March 2020, under section IV. Restorative Nursing Program Management, indicated that Developing a restorative nursing program includes patient need identification, program design, documentation and monitoring outcomes. The guideline also indicates that the program must Have measurable objectives and interventions that are documented in the care plan/clinical record.
F 0661 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Ensure necessary information is communicated to the resident, and receiving health care provider at the time of a planned discharge.** Based on record review and interview the facility failed to ensure discharge summaries (written review of the resident's course of treatment in the facility as well as follow up care recommended to facilitate residents transition from facility to another level of care) were completed for 3 of 3 residents (R #'s 60, 183 and 184) reviewed for discharge summaries. This deficient practice could negatively impact residents' health and continued recovery after being discharged as a comprehensive understanding of what is required to continue to be healthy or improve is necessary to optimize residents' health. The findings are: A. Record review of facility policy titled, 0PS406 Discharge Planning Process, revision date: 02/01/19 revealed, The center must develop and implement an effective discharge planning process that focuses on the patient's discharge goals, preparation of patients to be active partners and effectively transition them to post-discharge care, and reduction of factors leading to preventable re-admissions. All patients being discharged to home, to an assisted living facility, or another community-based setting will be given a Discharge Transition Plan and Discharge Packet. The Discharge Transition Plan will be reviewed with and given to the patient and/or resident representative along with the Discharge Packet upon discharge. B. On 08/25/20 at 2:55 pm, during an interview, the facility Social Services Director (SSD), revealed that he typically starts the discharge process by talking to the family and then the nurses usually complete the process to include preparing the medication summary and the nurses are the ones who have the resident sign the discharge plan form. C. Record review of facility Discharge Transition Plan, for R #60, revealed that there was no medication list attached to the Discharge Transition Plan and the document that indicates R#60 was educated and understood his discharge plan was not signed by R#60 or a nurse. D. On 08/31/20 at 2:30 pm, during a telephone interview, R #60's Significant Other/#1 Emergency Contact (listed on R #60's facility face sheet), revealed that R #60 came to her home after discharge so she could provide care for him while he recovered. The home health care that was planned for R#60 was never initiated. R #60 fell twice and had to be admitted to another facility. She revealed that she was not sure, if R#60 had discharge instructions. She revealed that the day R#60 was discharged , R#60 had a doctors' appointment and she picked him up from outside of the doctors' office building. She revealed that she had inquired with the facility, if R#60 should come back to the facility before she took him home and was told no (she did not remember who told her that). She revealed that she had picked up all R#60's belongings from the facility the day before that. E. On 08/25/20 at 4:00 pm, during an interview, Unit Manager #1 acknowledged that she had found after reviewing R#60's electronic Health Record, that there was no indication that the medication list and education was completed for R #60 before he discharged . She revealed that she spoke with the nurse who discharged R#60 and she was told that R #60 went to a doctor's appointment that day that his wife/significant other picked him up and went home from there. F. Record review of facility Discharge Transition Plan, for R #183, revealed that there was no medication list attached to the Discharge Transition Plan and the document that indicates R#183 was educated and understood his discharge plan was not signed by R#183 or a nurse. G. Record review of facility Discharge Transition Plan, for R #184, revealed that there was no medication list attached to the Discharge Transition Plan and the document that indicates R#184 was educated and understood his discharge plan was not signed by R#184 or a nurse. H. On 08/31/20 at 11:45 am, during an interview, the Director of Nursing (DON) confirmed that there should be a medication list attached to the Discharge Transition Plan and that they should also have a document showing evidence of resident teaching and understanding of the discharge plan, which includes a resident/resident representative signature and a nurses signature.
F 0679 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide activities to meet all resident's needs.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and interview the facility failed to implement an ongoing resident centered activities program for 5 (R #s 10, 13, 16, 29, and 70) of 7 (R #s 10, 13, 16, 25, 29,70 and 75) residents looked at for activities. This deficient practice does not create or encourage mental health well-being, cultural interest or an opportunity for growth for those residents wanting to participate in activities. The findings are: A. On 08/24/20 at 11:16 am, during an interview with R #16 stated that they used to do activities, but they have not been doing any for at least one month. B. On 08/24/20 at 1:30 pm, during an interview with R #29, she stated that they don't do activities at all. C. On 08/25/20 at 12:45 pm, during an interview with R #13, he stated they will bring around coloring sheets for them and that is all. He thinks, that because there are a lot of residents on [MEDICAL TREATMENT] (treatment that filters and purifies the blood using a machine. This helps keep your body in balance when the kidneys can't perform this function), they (staff) think they don't need to do anything else. R #13 stated it is very isolating. D. On 08/25/20 at 3:41 pm, during observation of activities, the Activities Assistant (AA) was setting up to do room bingo down 300 hall. E. On 08/25/20 at 3:41 pm, during an interview with Activities Director (AD) she was not able to give me a time or date when they last did room bingo on that hall. F. On 08/26/20 at 10:23 am, during an interview with the Activities Assistant, she stated that there are a lot of complaints about activities being too childish. She stated, yes, it does need to be addressed. They did use to have like a men's group run by a man, but it is not happening now. G. Record review of the activities log book for the month of August 2020, indicated that few if any activities are occurring for R #16, 13, and 29 on this hall. Findings for R# 70: H. On 08/25/20 at 8:33 am, during an interview with R #70, when asked if the resident participates in the activities offered by the facility, R#70 stated No, I can't play bingo because I can't see and I can't color because my hands hurt. Findings for R# 10: I. On 08/25/20 at 8:45 am, during an interview with R #10, when asked if the resident participates in the activities offered by the facility, R#10 stated I'm an adult, I don't want to color. J. On 08/26/20 at 10:33 am, during an interview with the Activities Assistant, when asked what type of activities occur in the facility, she stated, I clean their hands, smoke break (sit outside with them), play BINGO, teach classes on how to wear masks, we paint ornaments, we have paint kits, we color sacks, I give them Christian magazines, word searches, sudokus, paint nails, color, on some days we bring in a therapy dog. I have some projects where residents can paints an object, chair exercise, patio strolls, rosaries, prayer. On Sundays, we have bible classes and prayer class videos, activities packets, word searches, Pepsi bingo,(NAME)Mouse bingo, coloring pages. I have been using Crayola on the tablet to print out pages, and I deliver the newspaper. Depending on the resident, I do certain things. When asked what activity she presents to R# 70, she stated he will play bingo, but he likes to be left alone in his room. He likes to be alone with his roommate. He prefers 'more sophisticated things'. When asked what activity she presents to R# 10, she stated, it has been hard working with him, because he doesn't like any activities as they are to childish for him. R #10 and his roommate think its baby work. More than likely we will talk for 5 minutes and they will watch American Dad. (Name of R# 10) likes to work with paracords. We used to have a men's workshop, but since COVID, it has stopped.
F 0688 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to implement restorative services (a type of care a resident

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F 0688 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 2) receives to improve or maintain physical function), for 5 (R#'s 22, 25, 47, 68, and 71) of 5 (R#'s 22, 25, 47, 68, and 71) residents reviewed for range of motion and mobility. The lack of restorative services may prevent a resident's ability to maintain current activity of daily life functions. The findings are: A. On 08/28/20 at 10:33 am, during an interview with R# 22, the resident stated that he used to be very satisfied with the restorative services at the facility. He stated that there was a change in restorative services that has made him very dissatisfied. B. Record review of physician orders [REDACTED]. C. On 08/27/20 at approximately 11:30 am, during an interview with the Center Nurse Executive (CNE), when asked if there have been any changes in the restorative program, the CNE stated Our restorative program has been absorbed by the CNA's (certified nursing assistant). (Name of Corporation) has decided to cut our budget and restorative was one of the things to get cut. With the cut, it was determined that residents would receive restorative services through out the day during normal patient care. For example, during showers, after a brief change, etc,. D. Record review of physician orders [REDACTED].), including knee flexion/extension, hip abduction/adduction (Abduction is the movement laterally away from the midline of the body, while adduction is to move toward the body or across the midline), ankle pumps 10 reps times three, as well as bilateral hamstring stretching for 30 sec's times three. Pt to be seen for standing with FWW (front wheeled walker) for 10 sec's times three with max assist. E. Record review of the care plan for R# 68, reveals that the care plan was not updated with documentation of restoratives services or goals. F. Record review of the Treatment Administration Record for R# 68 does not include documentation of restorative services. G. Record review of physician orders [REDACTED]. all 2x15 (2 sets of 15 repetitions). H. Record review of the care plan for R# 71, reveals that the care plan was not updated with documentation of restoratives services or goals. I. Record review of the Treatment Administration Record for R# 71 does not include documentation of restorative services. J. On 09/01/20 at 3:26 pm, during an interview with R #71, when asked if restorative services were delivered, R# 71 stated, I think they were going to do something but they haven't done it. They told me they would help me flex my feet and do some other exercises. I would like to be able to do some exercises. I think it would help. K. Record review of physician orders [REDACTED]. three, AAROM left LE (lower extremity) including hip abd/add (abduction/adduction), hip internal external rotation, knee flexion/extension, ankle pumps 10 reps each, AROM right LE including hip abd/add, knee flexion/extension, ankle pumps 10 reps each. L. Record review of the care plan for R# 47, reveals that the care plan was not updated with documentation of restoratives services or goals. M. Record review of the Treatment Administration Record for R# 47 does not include documentation of restorative services. N. On 09/01/20 at approximately 1:00 pm, during an interview with Unit Manager #2, when asked to explain the restorative program, Unit Manager #2 stated when I started working here, I heard through the grapevine that the last unit manager who was hired was supposed to be in charge of restorative. I assumed that was me since I was the last unit manager to be hired however; I was never officially told that I would be in charge of restorative. So, I started putting the restorative referrals that came from therapy in a binder and I would save them in the binder. I had 2 restorative aids at that time (before COVID-19). One of them left when COVID-19 came and the other was out for a while because of COVID-19. The one who was out was supposed to instruct our aids on how to document however she was out for a long time and has only recently returned. The aids currently document on the back of the ADL (Activities of Daily Living) sheets. O. On 09/02/20 at 9:51 am, during an interview with Certified Nursing Assistant (CNA) #3, when asked how restorative services were delivered and documented, CNA #3 stated We can't do restorative. There's no time to do restorative. They give us orders in a verbiage that we cannot understand. I was only able to do restorative once. I cannot do it because there is no time, verbiage is unclear, and it's not safe. They have provided orders that do not make sense for the residents' abilities. For example- for one resident in this hall, they want to do something with him at the edge of the bed and he can't sit at the edge of the bed by himself, I can't help him to do his exercises if I am holding him and preventing him from falling over. For this other resident, they want her to walk, she can barely stand. Her knees are weak, and they sometimes buckle. It's not safe for me to do those with the residents. I would need another CNA to help me. I was not trained to do that. I think the previous restorative aid was trained because another person from another building came in to help her when she started. They said that it is all of the aids responsibility to do restorative. We haven't even had time to get our monthly weights. We are supposed to document on the very last page of the ADL sheet, but I can't write what I did with the resident in these short, small lines. P. On 09/02/20 the very last page of the ADL sheets for R# 68, 71, and 47 were requested from Medical Records, but unable to be located by the facility. Q. On 09/02/20 at 10:29 am, during an interview with Registered Nurse (RN) #2, when asked to explain the process of how care plan get updated and when restorative services would be added, RN #2 stated We update the care plan on admission, quarterly, annual, and with any significant change, we follow the MDS (Medical Data set) schedule and we care plan for whatever the MDS triggers. Everyone is responsible for their section. Therapy does not care plan. Nursing will print the therapy recommendations as nurse orders and put it in the TAR. The nurse should care plan it. If we see documentation of the restorative services, we will care plan for it. If we do not see documentation, we cannot care plan it or add it to the MDS. The CNAs should document the restorative services on the TAR. When I do the MDS, the documentation of restorative services should then be updated on the MDS. When that service is added to the MDS, the facility would receive a higher pay rate for that higher level of care. R. Record review of the facility's Restorative Nursing Guidelines, dated March 2020, under section IV. Restorative Nursing Program Management, indicates that Developing a restorative nursing program includes patient need identification, program design, documentation and monitoring outcomes. The guideline also indicates that the program must Have measurable objectives and interventions that are documented in the care plan/clinical record. S. Record review of the physician's orders [REDACTED].#25, indicated the following: Occupational Therapy (OT) clarification orders: Orders received, and evaluation completed. Pt (patient) will not benefit from skilled therapy services at this time due to poor tolerance for touch and stretches to RUE (right upper extremity). Recommend carrot (device to assist with contractures) for R (right) hand at this time for contracture (shortening of a joint) management and to reduce pain as well as prevent skin breakdown of the R (right) palm T. On 08/31/20 at 9:54 am, during an interview the Director of Rehab, she stated that they have tried to work with R #25. This is the second time they have tried to work with her because she has been referred to restorative a couple of times. She stated that R #25 was given a splint/carrot (relieves pressure of severely contracted hands and prevents excessive moisture, pressure, and the risk of puncture marks from the nails) for that hand, and she does see the order for this. She stated that this order is not discontinued. She stated that it looks like the Certified Nursing Assistant (CNA's) should be putting it on her hand daily. She also stated that R #25 does not like to be touched so it might be challenging. U. On 08/31/20 at 9:39 am, during an interview with CNA #2 she stated that she works on 300 hall, she stated that she does remember the brace for R #25 but she doesn't know what happened to it. V. Record review of the care plan for R #25 indicated that the brace and contracture were never care planned.
F 0693 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observations, and interviews, the facility failed to ensure the tube feeding (a device utilized to provide liquid nutrition and medications, via a tube into the stomach or intestine) for 1 of 1 (R #25) resident, was managed according to current acceptable standards of practice to ensure safety of the resident. This deficient practice could cause significant health problems, such as aspiration of feeding into lungs/subsequent pneumonia, for any resident who requires to be fed by tube. The findings are: A. Record review of the facility's policy titled, Medication Administration: Enteral (Enteral feeding refers to intake of food via the gastrointestinal (GI) tract. The GI tract is composed of the mouth, esophagus, stomach, and intestines), revision date of 11/01/19, revealed the following: .(before using) measure the tube (feeding) from the point of entry into the skin to the end of the tube to determine whether the catheter (tube) has migrated (may no longer be properly placed inside the resident) .If length of tube significantly changed, do not administer medication .(if measurements are correct) attach syringe to end of tube .instill sterile water into the tube through syringe, allow to flow by gravity .Administer medications individually .flush with at least 15 ml (milliliters) tap or sterile water between each medication .Keep head of bed elevated for at least 30 minutes after medication administration . B. Record review of R #25's face sheet revealed that the resident was admitted to the facility on [DATE], with the following Diagnosis: [REDACTED]. C. On 08/26/20 at 7:10 to 7:20 am, during the medication administration observation, the following was observed by the Licensed Practical Nurse (LPN) #1: 1. R #25 was lying supine

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F 0693 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 3) (on her back) with the head of bed (HOB) elevated approximately 10 degrees with a tube feed supplying nutrition into her feeding tube. 2. LPN #1 did not measure the feeding tube (to assure correct placement). 3. LPN #1 disconnected the feeding tube and injected (by syringe) a medication (without flushing the tube prior to the medication). 4. LPN #1 administered the rest of the medications together. D. On 08/26/20 at 7:20 am, during an interview, LPN #1 revealed that he was not aware of the protocols for giving medications separately via a tube feed and of the need to flush the tube with water before and after each medication administration. E. On 08/31/20 at 10:40 am, during an interview, the Center Nursing Executive revealed that she could not provide documentation of LPN #1's education on the facility's policy and protocols regarding the administration of medications via a feeding tube.
F 0695 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide safe and appropriate respiratory care for a resident when needed.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and interview, the facility failed to meet professional standards of quality for 1 (R #17) of 1 (R #17) resident by administering oxygen without a physician's order, without a care plan and with inconsistent monitoring of oxygen dose and residents response to therapy. If the facility is not administering and monitoring dose/and residents response consistently the resident was likely to not receive the therapeutic benefits, resulting in possible harm to the resident. The findings are: A. Record review of R #17's Face Sheet revealed, an admission on 06/21/20, indicating a primary [DIAGNOSES REDACTED]. B. On 08/24/20 at 10:47 am, during an observation of R #17 in her room, it noted that she was receiving oxygen (O2) by nasal cannula (N/C, tubing in nares) at 3 liters of oxygen. The tubing was not labeled as to the date when it was changed. C. On 08/24/20 at 11:00 am, RN (Registered Nurse) #1 confirmed that R #17, was receiving O2 and that the N/C tubing was not labeled with the date when it was changed. RN #1 revealed that the oxygen tubing was usually changed one time a week, but was not sure when or by whom. D. Record review of R #17's physician orders since the admission on 06/21/20, revealed no order for the oxygen therapy. E. Record review of R #17's Care Plan dated 06/21/20, indicated that oxygen therapy was not care planned nor was there indication for monitoring the oxygen saturations (measures the percentage of [MEDICATION NAME] blood cells, normal range would be 88% and above). F. Record review of nursing progress notes dated 08/21/20 to 08/31/20, for the documentation of O2 saturations and the amount of O2, revealed the following: 1. On 08/21/20 at 10:21 pm, the O2 saturation was 96% with N/C (this infers oxygen was flowing, the amount of amount of oxygen not documented). 2. On 08/22/20, (no time indicated) there was no documentation of O2 saturation or oxygen therapy found. 3. On 08/23/20 at 9:00 am, the O2 saturation was 95%. It was not documented whether this was on room air (RA) or the amount of oxygen therapy. 4. On 08/24/20 at 3:44 pm, the O2 saturation was 90% on RA. 5. On 08/25/20 at 3:37 pm, the O2 sat was 93% on RA. 6. On 08/26/20 and 08/27/20, there was no documentation of O2 saturation or oxygen therapy found. 7. On 08/28/20 at 9:19 am, the O2 saturation was 90% on RA. 8. On 08/29/20 at 8:58 am, the O2 saturation was 95%. It was not documented whether this was on RA or the amount of oxygen. 9. On 08/30/20 at 9:52 am, the O2 saturation was 90% on RA. 10. On 08/31/20 at 9:21 am, the O2 saturation was 93% on N/C. No documentation was found as to what O2 parameters are acceptable for the resident or what O2 liter flow she was on. G. On 08/25/20 at 3:50 pm, during an interview, the Unit Manager #1 acknowledges there was no physician order for [REDACTED].
F 0697 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide safe, appropriate pain management for a resident who requires such services.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility did not assure needed pain relief for 1 (R #182) of 1 (R #182) resident who was assessed for pain management in a timely manner. This deficient practice could affect any of the facility's 85 residents listed on the facility census provided by the Center Executive Director on 08/24/20. If resident's pain/comfort were not routinely evaluated and treated in a timely manner with the understanding of the length of time the ordered pain-relieving medications were effective for the residents' comfort and over-all well-being will likely be adversely affected. The findings are: A. On 08/24/20 at 10:02 am, during an interview, R #182 stated when questioned regarding if she received pain medications when she needed them. She stated, (It) takes a long time, about 30 minutes .they (the nurses) have to look in the computer I guess (before providing ordered pain medications). B. Record review of R #182's face sheet indicated an admission on 08/08/20 for aftercare of having a right hip replacement. C. Review of residents' nursing progress notes dated 08/09/20, revealed the following: reason for stay/documentation: Teaching and Training Therapy Post-Op (operative) Care Pain Management right hip arthroplasty (hip replacement). D. Record review of R #182's care plan dated 08/09/20, revealed the following: Resident exhibits or is at risk for alterations in comfort related to surgical post-op. Resident will achieve acceptable level of pain control (no date indicated) days. Evaluate pain characteristics: quality, severity, location, precipitating/relieving factors; Nrsg (Nursing) (will) Utilize the pain scale; Nrsg will advise resident to request pain medication before pain becomes severe; and Nrsg will complete the pain assessment per protocol. E. Record review of the Provider's orders dated 08/25/20, revealed two pain medications ordered on a as needed (PRN) basis: 1. [MEDICATION NAME] HCl (a narcotic pain medication most often used to treat moderate to severe pain) Tablet 5 mg (milligrams), Give 5 mg by mouth every 4 hours as needed for pain; and 2. Tylenol Tablet 325 mg ([MEDICATION NAME]) (most often used to treat mild to moderate pain), Give 650 mg by mouth every 6 hours as needed for pain. F. Record review of Medical record found various areas where residents pain level was documented. None were consistently utilized. 1. The Medication Administration Record [REDACTED]. The nursing progress notes. 3. The, Weights and Vitals Summary,in the electronic health record (EHR). 4. The user defined assessment for pain (not found in R #182's records). 5. A Pain Monitoring Assessment form can be used per report of Director of Nursing. (DON) G. Record review of R #182's medical records in Weight and Vitals Summary, (example where pulse respirations and blood pressure are recorded, included pain scale) dated 08/09/20 through 08/23/20, regarding the pain scale assessment using the numerical pain scale (requires a person to rate their pain from 0 to 10, usually interpreted as, 0 being no pain, 1- 3 mild pain, 4 - 7 moderate pain and 8-10 severe pain) revealed the following: 1. On 08/09/20 at 11:28 am, R #182 reported her pain level as a 6; 2. On 08/10/20, no pain assessment documentation was found in the chart for that day; 3. On 08/11/20, no pain assessment documentation was found in the chart for that day; 4. On 08/12/20 at 9:27 pm, R #182 reported her pain level as 0; 5. On 08/13/20, no pain assessment documentation was found in the chart for that day; 6. On 08/14/20, no pain assessment documentation was found in the chart for that day; 7. On 08/15/20 at 11:47 am, R #182 reported her pain level as a 8; 8. On 08/16/20 at 11:04 am, R #182 reported her pain level as a 5; 9. On 08/17/20, no pain assessment documentation was found in the chart for that day; 10. On 08/18/20, no pain assessment documentation was found in the chart for that day; 11. On 08/19/20, no pain assessment documentation was found in the chart for that day; 12. On 08/20/20, no pain assessment documentation was found in the chart for that day; 13. On 08/21/20, no pain assessment documentation was found in the chart for that day; 14. On 08/22/20 at 8:47 am, R #182 reported her pain level as 0; and 15. On 08/23/20 at 9:50 am, R #182 reported her pain level as a 3 H. Record review of residents' MAR for 08/15/20 to 08/24/20, indicated PRN pain medications given in response to resident's pain level report revealed the following: 1. On 08/15/20 at 5:30 pm, Tylenol 650 mg was dispensed; 2. On 08/16/20 at 12:23 pm, Tylenol 650 mg was dispensed; 3. On 08/17/20 at 9:18 am, Tylenol 650 mg was dispensed; 4. On 08/18/20. No Tylenol or [MEDICATION NAME] was dispensed that day; 5. On 08/19/20 at 10:28 am, Tylenol 650 mg was dispensed; 6. On 08/20/20 at 9:01 am, Tylenol 650 mg was dispensed and at 3:41 pm, Tylenol 650 mg was dispensed; 7. On 08/21/20 at 4:12 pm, Tylenol 650 mg was dispensed; 8. On 08/22/20 at 3:21 pm, Tylenol 650 mg was dispensed; 9. On 08/23/20 at 5:18 pm, Tylenol 650 mg was dispensed; and 10. On 08/24/20 at 4:47 pm, Tylenol 650 mg was dispensed. I. Record review of nurse progress notes dated 08/15/20 through 08/24/20, revealed documentation of right knee/hip pain assessments, as indicated: 1. On 08/15/20 at 10:11 pm, R #182 reported her pain level as a 8; 2. On 08/16/20 at 8:11 am, R #182 reported her pain level as a 5 and at 11:11 pm, as a 5; 3. On 08/17/20 at 11:11 pm, R #182 reported her pain level as a 5; 4. On 08/18/20, no pain assessment documentation was found in the chart for that day; 5. On 08/19/20 at 10:28 am, R #182 reported her pain level as a 6; 6. On 08/20/20 at 3:41 pm, R #182 reported her pain level as a 5; 7. On 08/21/20 at 4:12 pm, R #182 reported her pain level as a 5 and at 10:35 pm, as a 5; 8. On 08/22/20 at 10:35 am, R #182 reported her pain level as 0 and at 3:21 pm, as a 6 and at 4:25 pm, 4; 9. On 08/23/20 at 9:35 am, R #182 reported her pain level as a 3 and at 11:35 pm, as a 3; and 10. On 08/24/20, no pain assessment documentation was found in the chart for that day. J. Record review of facility's policy titled, Pain Management, revision date of 11/01/19, revealed the following: .At a minimum of daily, patients will be evaluated for the presence of pain by making an inquiry of the patient or by observing for signs of pain .Electronic Order Management (EOM): Document pain presence on the Medication Administration Record [REDACTED]. K. No documentation of resident's pain level at the time the PRN medication was given was found on the MAR indicated [REDACTED]. No documentation of resident's pain quality, severity, precipitating/relieving factors or of resident's preference for Tylenol or [MEDICATION NAME] was noted on this review as would be consistent with current professional practice for nursing

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	325042	A. BUILDING _____ B. WING _____	09/02/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
UPTOWN 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.

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F 0697 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 4) assessment of pain. L. On 08/26/20 at 3:59 pm, during an interview, the Center Nurse Executive when asked regarding the pain management for R #182, she stated that there was no documentation of pain levels on the MAR for August 2020 . She also stated that R #182 did not have a pain monitoring/assessment form in her medical records.
F 0761 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Many	**Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.** Reference NFPA 101, 2012 Edition 7.2.1.15 Inspection of Door Openings. 7.2.1.15.1* Where required by Chapters 11 through 43, the following door assemblies shall be inspected and tested not less than annually in accordance with 7.2.1.15.2 through 7.2.1.15.8: (1) Door leaves equipped with panic hardware or fire exit hardware in accordance with 7.2.1.7 (2) Door assemblies in exit enclosures (3) Electrically controlled egress doors (4) Door assemblies with special locking arrangements subject to 7.2.1.6 7.2.1.15.2 Fire-rated door assemblies shall be inspected and tested in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. Smoke door assemblies shall be inspected and tested in accordance with NFPA 105, Standard for Smoke Door Assemblies and Other Opening Protectives. 7.2.1.15.3 The inspection and testing interval for fire-rated and nonrated door assemblies shall be permitted to exceed 12 months under a written performance-based program in accordance with 5.2.2 of NFPA 80, Standard for Fire Doors and Other Opening Protectives. 7.2.1.15.4 A written record of the inspections and testing shall be signed and kept for inspection by the authority having jurisdiction. 7.2.1.15.5 Functional testing of door assemblies shall be performed by individuals who can demonstrate knowledge and understanding of the operating components of the type of door being subjected to testing. 7.2.1.15.6 Door assemblies shall be visually inspected from both sides of the opening to assess the overall condition of the assembly. NFPA 80 Standard for Fire Doors and Other Opening Protectives, 2010 Edition Fire Doors 5.2.3 Functional Testing. 5.2.3.1 Functional testing of fire door and window assemblies shall be performed by individuals with knowledge and understanding of the operating components of the type of door being subject to testing. 5.2.3.2 Before testing, a visual inspection shall be performed to identify any damaged or missing parts that can create a hazard during testing or affect operation or resetting. 5.2.4 Swinging Doors with Builders Hardware or Fire Door Hardware. 5.2.4.1 Fire door assemblies shall be visually inspected from both sides to assess the overall condition of door assembly. 5.2.4.2 As a minimum, the following items shall be verified: (1) No open holes or breaks exist in surfaces of either the door or frame. (2) Glazing, vision light frames, and glazing beads are intact and securely fastened in place, if so equipped. (3) The door, frame, hinges, hardware, and noncombustible threshold are secured, aligned, and in working order with no visible signs of damage. (4) No parts are missing or broken. (5) Door clearances do not exceed clearances listed in 4.8.4 and 6.3.1.7. (6) The self-closing device is operational; that is, the active door completely closes when operated from the full open position. (7) If a coordinator is installed, the inactive leaf closes before the active leaf. (8) Latching hardware operates and secures the door when it is in the closed position. (9) Auxiliary hardware items that interfere or prohibit operation are not installed on the door or frame. (10) No field modifications to the door assembly have been performed that void the label. (11) Gasketing and edge seals, where required, are inspected to verify their presence and integrity. Fire doors to be inspected annually: All doors in a fire rated room/hallway with self-closers including smoke compartment doors. Based on record review and interview, the facility failed to ensure fire and smoke doors in the facility were inspected and tested at least every 12-months as required by NFPA 101, (Inspection of Door Openings). In the event of fire, any door in a designated means of egress path may not resist the passage of smoke/fire to and from other areas of the facility, which presents a risk of potential harm to all ninety three (93) residents as identified by the Daily Census report provided by the Administrator on 09/08/20. The findings are: A. Record review of the facility maintenance records revealed that the most recent annual fire and smoke door inspections was on 07/17/19. B. On 09/08/20 at 11:00 am, during interview, the Maintenance Director stated that he was not aware if an annual inspection was done.
F 0804 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature.** Based on record review, observation, and interview, the facility failed to ensure that meals were served at an appetizing temperature and palatable, for 5 (R #10, 39, #44, #59, and #74) of 5 (R #10, #39, #44, #59, and #74) residents reviewed for meal quality. This deficient practice reduces residents' ability to make choices about important aspects of their lives and may decrease their quality of life by not having nutritious palatable food and food served at the proper temperature. The findings are: Findings related to R #59: A. On 08/24/20 at 9:22 am, during an interview, R #59 stated the food was not edible in her opinion and that she was spending a lot of money ordering snacks online to get her by. She stated the food was cold and just tasteless for all meals. She stated she had written some complaints that were taken to the Dietary Manager about the food and had never received a follow-up. Findings related to R #10: B. On 08/24/20 at 1:16 pm, during an interview, R #10 stated that he has had a really hard time requesting the food that he prefers, and he has been told that the facility was out of eggs or the dietary staff would send him scrambled eggs hoping he won't recognize the difference. He stated that he has had no way to file a grievance until recently, because the facility was not doing them. He stated that the staff would write his complaints down about the food and never return with a follow up. He stated at one time he showed Unit Manager #2 the eggs that he received, and she said that the eggs looked terrible as well and she sent the eggs back to the kitchen. C. On 08/31/20 at 10:33 am, during an interview, Unit Manager #2 confirmed that R #10s eggs looked terrible and she sent the eggs back to the kitchen. Findings related to R #74: D. On 08/24/20 at 2:15 pm, during an interview, R #74 stated that she had requested that her eggs be served to her fried and they don't give them to her fried, but they give other residents fried eggs. She stated the facility has run out of food in the past and that last night they served carne adovada, but it had spinach in it. She stated every day the dietary staff give you a choice of two options, and they never give you what you choose. She stated she was tired of going hungry and the other day she bought Chinese chicken for anyone who wanted to eat it as well. She stated on another night she asked for a chef salad and received lettuce, but no eggs, no tomatoes, and nothing else was on the salad. She stated on another occasion, the minestrone had no beans, no macaroni and no vegetables. She stated the meals are very depressing. Findings related to R #43: E. On 08/24/20 at 2:16 pm, during an interview, R #43 stated the food was terrible and he can't believe how small the portions are. He stated the quality of the food was awful, and most of the time the meals come cold. He stated he has given verbal complaints and nothing changes. He stated he just has his mother bring him most of his meals when she can, and his friends also bring him food. F. On 08/25/20 at 12:13 pm, during the taste test tray revealed the temperature of the hamburger was at 80 degrees, should have been at 135 degrees and the fries were cold. The food was tasted and was found to be cold. G. On 08/26/20 at 7:13 am, during an interview, R #44 stated he had ordered bacon with his breakfast. Resident showed his breakfast tray which contained on the Styrofoam plate which contained two fried eggs and a tortilla. Certified Nursing Assistant (CNA) walked into the room and R #44 requested his missing bacon. The CNA stated that she would be right back with it. Resident stated it happens a lot and the staff hope you just forget about it or don't notice. H. On 08/26/20 at 8:59 am, during an interview, the Dietary Manager stated she talks with residents about their food related concerns and she changes tickets as requested and tries to fix things. She stated they normally do not run out of fresh eggs, but they have liquid eggs available in case they do. She stated she talks to the residents during mealtimes, resident council meetings, any filed grievances, and she also checks in after meals to see how the food was and things they can improve on. She stated prior to last month the last resident council meeting was held in March 2020 and she normally asks the group in attendance for recommendations and inquiries about any issues with the food. She stated residents will communicate issues with the staff by leaving them notes. Stated that documentation of these notes given for food complaints are not documented anywhere. She stated most of the complaints come from breakfast due to eggs being in the Styrofoam plates and she believes eggs in the bowls keep a better temperature for the residents. She stated they are working on better quality and keeping the food warm for the resident's. I. On 08/26/20 at 3:46 pm, during an interview with the Interim Administrator, she stated they will be going room to room to follow up on any grievances filed from April 2020 through July 2020, that were missed or not addressed and catch up on them as soon as possible. She stated the food has been an ongoing issue and it is being addressed at the Quality Assurance Performance Improvement (QAPI) and resident council meetings. J. Record review of the facility's Food policy, revised on 10/27/19, revealed the following: .If the patient/resident makes a request during meal

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F 0804 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 5) service, Food and Nutrition Services prepares and serves the meal according to preferences and diet restrictions .Serve selected food and communicate with patient/resident the rationale of the inappropriate choice.
F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Many	**Provide and implement an infection prevention and control program.** Based on observation and interview, the facility failed to store linens in a manner that would prevent the spread of infectious agents. The laundry staff stored clean laundry in the dirty room. This deficient practice is likely to affect all 85 residents identified on the census provided by the Interim Administrator on 08/24/20 by potentially exposing clean laundry to infectious agents. A. On 09/02/20 at 2:36 pm, during an observation of the laundry room. There were 2, portable, hanging racks, each containing clean resident clothes, parked in the dirty area, less than 12 inches away from 2 housekeeping carts. B. On 09/02/20 at 2:40 pm, during an interview with Housekeeping Manager when asked if the racks containing resident clean clothes were normally stored in the dirty area of the laundry room, the Housekeeping Manager confirmed that they are normally stored in that area, as space in the clean room is limited. C. Record review of the facility's policy titled Linen Handling, revised on 03/01/2018, states the following: Policy: All linen will be handled, stored, transported, and processed to contain and minimize exposure to waste products. All soiled linen will be handled the same, using Standard Precautions . Purpose: To provide effective containment and reduce potential for cross-contamination from soiled linen. Process: 1. Maintain clean linen in a closed storage area. Keep clean linen covered. Keep clean storage area separate from soiled storage area.