STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	325056	A. BUILDING _____ B. WING _____	**06/03/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
SOMBRILLO NURSING FACILITY	**1011 SOMBRILLO COURT LOS ALAMOS, NM 87544**

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 0600 **Level of harm -** Actual harm **Residents Affected -** Few	**Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure that residents were free from neglect for 1 (R #1) of 3 (R #1, 2, and 3) residents reviewed for falls. This is indicated by nursing staff not following physicians orders by not providing 1:1 supervision. This deficient practice likely resulted in R #1 being admitted to the hospital with [REDACTED]. The finding are: A. Record review of the admission orders [REDACTED].Ambulates (walks) with assist and independently (but falls) . B. Record review of the Care Plan dated 02/11/20 for R #1 revealed, Problem Category: Falls. (Name of R #1) is at risk for falls r/t (related to) increased cognitive decline (when your brain doesn't work as well as it used to) . Goal: (Name of R #1) will remain free from injury with this POC (Plan of Care) thru next review. Approach: 1) Give (name of R #1) verbal reminders not to ambulate/transfer without assistance. 2) Provide (name of R #1) an environment free of clutter. C. Record review of the Care Plan dated 02/11/20 for R #1 revealed, Problem Category: ADL (Activities of Daily Living)/Rehabilitation Potential . Goal: ADL approaches to meet resident's needs. Approach: .Walking Ability: Requires cane and supervision. D. Record review of the (Name of hospital) admission documentation dated 05/17/20 for R #1 revealed, Diagnosis: [REDACTED]. Presenting complaint: EMS (Emergency Medical Services) states: pt (patient) fell from standing position, sustaining contusion (bruise) to right brow, c/o (complains of) pain to left hip . Fall Risk .The patient has a history of falls . Assessment: 8:47 pm . Derm (dermatological - skin): Bruising that is on right side of forehead swelling. Injury description: Head injury sustained to right side of forehead is closed, did not have loss of consciousness (alertness), was sustained 30-60 minutes ago . 5/18 ED (Emergency Department) course . the CT (computerized tomography - type of x-ray) scan of the brain, as read by the radiologist (specialist in medical imaging) showed . trace right subdural (collection of blood on the brain surface) measuring 3 cm (centimeters) . E. Record review of the (Name of hospital) admission documentation dated 05/18/20 for R #1 revealed, Chief Complaint: Fall. History of Present Illness: .She was transferred today from (name of hospital) emergency room to (name of hospital) downtown on account of traumatic subdural hemorrhage (bleeding between the brain cover and the brain caused by injury) from a fall . Active Hospital Problems - Diagnosis: [REDACTED]. Repeat CT showed subdural hematoma measuring up to 7 mm (millimeters), likely stable . (name of physician) consulted this morning again on 05/18, he does not think that patient needs intervention at this point . F. Record review of the Facility Incident Investigation dated 05/17/20 for R #1 revealed, Incident type: Fall . unwitnessed fall. Resident found laying on right side . List interventions in place to prevent incident: 1:1 (one to one) when resident returns from hospital . List interventions to attempt to prevent reoccurrence: Other (is marked) Care Plan Initiated/Modified (is marked). Specify: 1:1 G. Record review fo the (Name of hospital) admission documentation dated 05/19/20 for R #1 revealed, History of Present Illness . This [AGE] year old white female, transported by paramedic (emergency medical provider) ambulance from skilled nursing facility, (name of facility), was found on the floor after an unwitnessed fall this evening. The patient was treated by me 2 nights earlier for a similar episode of fall which resulted in a small subdural hematoma to the right side . and has now suffered another fall causing laceration to her right forehead, significant bruising on her entire right face . ED course . sent to CT for CT scan of head and cervical spine (neck) . the CT scan was read by the radiologist as showing subacute (recent onset) 6 mm right subdural hematoma with mild mass effect on cerebral sulci (grooves on the surface of the brain). Small subdural blood along the right tentorium (membrane that covers the brain). Focal hemorrhagic contusion (damaged brain tissue) in anterior (front) aspect of right temporal (bottom) lobe. 3 mm midline shift to left . Fracture to anterior wall and lateral (side) wall of right maxillary sinus (sinus bone). Fracture of floor of right orbit (bones of the eye socket) . H. Record review of the Facility Incident Investigation dated 05/19/20 for R #1 revealed, Incident type: Other: Fall . found on floor . Potential contributing factor(s) related to the occurrence . lack of 1:1 coverage during fall . I. Record review of the Physicians Orders dated 05/19/20 for R #1 revealed, Start date: 05/19/20. Order Description: One on one care following a fall with injury. J. Record review of the Progress Notes dated 05/19/20 at 2:32 pm for R #1 revealed, Resident had just returned to facility. Resident had slid off her wheelchair but the Certified Nurses Assistant (CNA) who was helping nurse transfer resident was able to catch her. It was a witnessed incident no injuries occurred. K. Record review of the Progress Notes dated 05/19/20 at 3:40 pm for R #1 revealed, .is a 1:1 . L. Record review of the Progress Notes dated 05/19/20 at 5:46 pm for R #1 revealed, .I called the on call to get an order for [REDACTED]. Record review of the Progress Notes dated 05/19/20 at 10:27 pm for R #1 revealed, This nurse was getting report from day nurse (name of nurse) when was called by (name of) CNA that resident was on the floor . this nurse and (name of nurse) went to the residents room and found resident lying on her right side with a puddle of blood noted by resident's right side of head . N. Record review of the Progress Notes dated 05/20/20 at 12:09 am for R #1 revealed, When this nurse and (name of nurse) went to resident's room when called by (name of) CNA resident was in room alone, with no one on one sitter, CNA (name of) had no one to replace. O. Record review of the Progress Notes dated 05/20/20 at 12:16 am for R #1 revealed, Called ER and spoke to (name of registered nurse) that resident had a possible bleed to the right side of residents head and a fracture to right arm . P. On 06/03/20 at 4:40 pm during an interview with the Assistant Director of Nursing (ADON) she stated that R #1 was sent to theER on ,[DATE] due to a fall and was transferred out to (name of hospital) due to subdural hematoma. She stated that when R #1 came back from the hospital on May 19th she was very confused. She stated that R #1 was sent out to the ER again on 05/19 for another fall and that R #1 received fractures to her face following this fall and was sent out to (name of hospital) on 05/20. ADON stated that R #1 was housed on the West Wing of the facility and that normally there would be one Certified Nurse Assistant (CNA) for the night shift on the West Wing, but that if any resident required 1:1 services there would then be the regular CNA and also the CNA for 1:1 services. ADON stated that on May 19th that the CNA whose shift was ending left before the CNA whose shift was starting was physically in R #1's room and that the nurse on duty that night was aware of this. ADON stated that she was in the process of calling in agency staff because there were two call ins that night and there was no one to relieve the 1:1 CNA. She stated that R #1 was alone in her room for about three minutes and that is when she fell .

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.