| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 325068 | A. BUILDING _____ B. WING _____ | 08/11/2020 |

| NAME OF PROVIDER OF SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP |
|---|---|
| BELEN MEADOWS HEALTHCARE AND REHABILITATION CENTER | 1831 CAMINO DEL LLANO BELEN, NM 87002 |

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) |
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| F 0684<br><br>**Level of harm -** Actual harm<br><br>**Residents Affected -** Few | **Provide appropriate treatment and care according to orders, resident's preferences and goals.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on record review and interview, the facility failed to provide care for 1 (R #1) of 5 (R #s 1, 2, 3, 4, and 5) residents reviewed for falls, by not initiating neuro checks after R #1 fell hitting his head and failed to implement preventitive interventions when R #1 continued to experience injuries from falls. This deficienct practice resulted in R #1 sustaining a brain bleed and broken ribs following 3 falls in 4 days. The findings are: A. On 08/06/20 at 3:45 pm a family member of R#1 stated, Originally my father went to the (name of hospital) on the 6th (07/06/20) for a broken hip. He was there for about 2 weeks. He was then admitted to (name of facility) on 07/22/20. During the time that he was there, I received a call on a Tuesday, early in the morning, that he had fallen. They found him in good spirits and he was ok. They called me consecutively for 3 days to tell me that he had fallen. I went to see him through the gate outside and we were about 20-30 feet apart. I received a call on Friday that he had fallen again that he had a laceration on his left arm and that he had bumped his ear and that he had a small bruise. On Saturday they called me at 2 am to let me know he had fallen again but that he was fine. My family then went to go see him. His left ear was black and blue. The laceration on his arm was bad. We didn't know anything about the broken ribs. We decide to send him to the hospital. We called the ambulance and asked them to send him to the (name of hospital). He was not able to go to the (name of hospital), so they sent him to (name of hospital). They admitted him to the neuro ICU (Intensive Care Unit) and we received a report back that he was bleeding in his brain, broken ribs on his left side, and bruising all over his body. He was not himself, not responsive, and totally dazed. While we pulled him out of (name of facility), we had to sign a form for him to leave Against Medical Advice (AMA). That was then sent over to Adult Protective Services. I was questioned why I pulled him out of the facility and I told them to' save his life '. They (the facility) didn't want to let him go to the hospital. He suffers from dementia and Alzheimer's. He has worsened, and he is very fidgety and high anxiety. He gets up and he needs something to protect him or to watch him. They also received that directive from the (name of hospital). I was called 3 times to notify me of the falls. They called me each time very early in the morning, one at 2 am, 5 am, and 6 am. They were calls form the nurse on her private phone. They said that they found him on the floor. On the first time when he fell , I asked that they do something, they said they would put mats and I asked that he get 1-on-1 services. They were not able to provide 1-on-1 so I told them to do what they can . When they called me on that Friday or Thursday, they told me that he had fallen; he had a bruised left ear and a laceration on his upper forearm. When I asked how bad, she said 'oh, it's not bad, we bandaged him up '. I didn't realize that the trauma to his head led to bleeding in his brain. His physician said that if there are any bruising, he needs to have an MRI (Magnetic resonance imaging is a medical imaging technique used in radiology to form pictures of the anatomy and the physiological processes of the body) because he is on [MEDICATION NAME] (an anticoagulant medicine used to prevent and treat the symptoms of blood clots). B. Record review of hospital documentation reveals that R#1 was admitted on [DATE] at 2:15 pm (after his stay at the Long Term Care Facility). Upon evaluation, he was found to have bilateral subdural hemorrhages (A pool of blood between the brain and its outermost covering)- R SAH (Right Subarachnoid hemorrhage: Bleeding in the space between the brain and the tissue covering the brain)/subdural hematoma and rib fractures on the 9th and 10th ribs. C. Record review of the facility progress notes dated 07/21/20 indicates that the patient was admitted for the following reasons: Teaching and Training, Therapy fracture, status [REDACTED]. Needs assistance of 1-2 people to get out of bed . D. Record review of the Treatment Administration Record indicates that R#1 was ordered to receive [MEDICATION NAME] Sodium Solution 40 mg/0.4 ML (an anticoagulant medicine used to prevent and treat the symptoms of blood clots) by injecting 1 syringe subcutaneously one time a day for anticoagulant, until 07/26/20. This medicine was administered daily, as ordered on [DATE] to 07/24/20. E. Record review of assessments indicate that there were 3 incidents where R#1 experienced a Change in Condition on the following dates: 07/22/20, 07/24/20, and 07/25/20. F. Record review of the progress notes indicate that on 07/22/20, R#1 experienced an unwitnessed fall where no injuries were observed, and floor mats were then implemented. G. Record review of the Risk Management System (RMS) report, dated 07/22/20, indicates that R#1 was found where a Level of consciousness is 1X (oriented to self), resident baseline is confused. Patient found on floor by CNA (Certified Nursing Assistant). Patient potentially rolled out of bed. H. When asked if a Neurological Assessment of the fall on 07/22/20 was completed, the document was unable to be locate by facility staff. I. Record review of the progress notes indicate that on 07/24/20, R#1 occasionally tries to get out of bed/wheel chair on his own. He sustained a minor skin tear to his left hand (rear) from his wheel chair while trying to get out of his bed. It was immediately cleansed and [MEDICATION NAME] dressing applied. No complaint for pains or discomfort. Will continue to monitor. J. Record review of the progress notes indicate that on 07/25/20, R#1 was found on the floor in his room around 3:30 am. Denies any pain or discomfort at time of report. Further review reveals that the resident obtained a scratch on his left upper back. K. When asked if a RMS report and a Neurological Assessment of the fall on 07/25/20 was completed, the Unit Manager stated that a neurological assessment was not initiated. When asked why it was not initiated, she stated that the resident left the facility that same day. L. Record review of the Care Plan for R#1 did not include any updates or entries related to the resident's falls, fall risk or medication regimen. M. On 08/11/20 at 4:05 pm, during an interview with the facility Center Nurse Executive (CNE), when asked to discuss R#1, the CNE stated We have been the only center that has been open to admissions. We have had many people come in who are substance abusers or alcohol dependent. At this time, we got a large influx of residents. They would come, like 7 at a time. Some just didn't want to be here. They would tell us that they didn't want to be here . In this case, we let them know that if they leave AMA, it's a different process. His case was different, he didn't want to be here form the get go. He sustained a fall and then he left. Typically, those who leave AMA, they are unhappy when they get here, they have high expectations. With COVID, they have to have the same staff on the halls. They told me that the son came over here, and they did a window visit that day and he said he wanted to take him home. He wasn't satisfied with the process- he fell , and he didn't want him to have falls. When asked to explain the process of what should happen when someone falls, the CNE stated Typically, if the CNA finds them, they do not move the resident for C-spine precautions. The nurse should assess them. They have 2 hours to report that to me. They should also accompany the fall with an RMS report, neuro checks, then contact the provider and the family. They should also provide a nurse's note. When asked who would send the resident to the hospital, the CNE stated the provider would make the discretion to send a resident to the hospital. The provider is receiving information from the nurse and what the nurse tells the provider would warrant a trip to the hospital. N. On 08/11/20 at 4:12 pm, during an interview with the Unit Manager, when asked to explain what she can recall about R#1, the Unit Manager stated there was a window visit, the grandson called R#1's son. The grandson said he had a fall but that he nicked his ear. His ear was large and purple. His reasoning to take him out of the building was that he wanted to take him somewhere where he would not fall as much. The day he left, he had a |

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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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 0684<br><br>**Level of harm -** Actual harm<br><br>**Residents Affected -** Few | (continued... from page 1)<br>gash in his ear, and a laceration on his arm. When asked what should be considered if a resident who was prescribed an anticoagulant had fallen and was later found to have bruising, the Unit Manger stated they would consider sending him out. If he was on blood thinner, they should monitor. Look for more bruising. I would have called to report the bruised ear. O. Record review of a statement from the facility physician states In response to (name of R#1) family's allegations of neglect of patient at (name of facility)- Patient was admitted to (name of hospital) for a fall on 07/06/20 resulting in a right intertrochanteric (bony protrusions on the femur where the muscles of the thigh and hip attach) [MEDICAL CONDITION] which required surgical intervention. Patient has a history of falls at home. He was admitted to (name of LTC facility) on 07/21/20. On 07/22/20 patient sustained a fall out of bed, the bed was in the lowest position and a fall mat was in place. The nurse notified me, the provider at the facility, and I assessed the patient after getting report from the nurse. Patient appeared to be at baseline confusion due to dementia and had no physical signs of the fall, such as scratches, bruising bleeding, ect. I determined that a transfer to the hospital may be more risky to patient's health as I felt he had no indication to go out and given the risk of COVID-19. I again saw the patient on 07/23/20, he was again seen in bed which was at the lowest position with a fall mat in place. Patient again had a fall on 07/25/20 from bed in the lowest position onto the fall mat at 5:10 am. On call provider was notified and determined this fall did not warrant a trip to the hospital due to nursing assessment, which found a small non-bleeding scratch on patient's left upper back. No other injuries were noted. The family of the patient was notified after each fall and on 07/25/2020 they decided to take patient out of the facility to take home against medical advice- they believed that since we would not restrain patient that he was not safe at the facility. After being taken out of the facility, Ombudsman was contacted and informed of the situation, in turn they contacted Adult Protective Services due to concerns for patient safety. It is my opinion that an injury that (name of R#1) has sustained after 07/25/2020 at 1:00 pm (when resident was discharged ) is not the responsibility of (name of facility). P. Record review of the facility policy titled Falls Management, dated 02/18/20, indicates that the purpose of the policy is to reduce risk for falls and minimize the actual occurrence of falls and to address injury and provide care for a fall. Further review of the policy indicates that Practice Standards include the flowing: 1. Identify patient's fall risk by reviewing the Electronic Medical Record Systems and Non-electronic Medical Records Systems. 2. Communicate patient's fall risk status to caregivers. 3. Develop individualized plan of care. 4. Review and revise care plan regularly. 5. If patient falls: 5.1. Follow 'Guidelines for Managing a Fall' if a staff member is present when the fall occurs. 5.2. Utilize the 'Fall Response Protocol ' for both witnessed and unwitnessed falls. 5.2.1 Perform Neurological Evaluation for all unwitnessed falls and witnessed falls with injury to the head or face. 5.3. Document accident/incident: 5.3.1. As a new event in the Risk Management System (RMS) 5.3.2. On a Change of Condition Note 5.3.3. On the 24-Hour Report 5.3.4. Investigation using the Fall Investigation/QA and other appropriate tools in RMS. 5.4. Update care plan to reflect new interventions. 5.5. Conduct interdisciplinary team meeting within 72 hours of fall. 5.6. The Center Executive Director and Center Nurse executive will conduct a post fall review. Q. Record review of the facility policy titled Neurological Evaluation, dated 12/20/19, indicates that the Neurological evaluation will be performed as indicated or ordered. When a patient sustains an injury to the head or face and/or has an unwitnessed fall, neurological evaluation will be performed: every 15 minutes x (for) two hours, then every 30 minutes x (for) two hours, then every 60 minutes x (for) four hours, then every 8 hours until at least 72 hours has lapsed. |