| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | **325123** | A. BUILDING _____ B. WING _____ | **05/22/2020** |

| NAME OF PROVIDER OF SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP |
|---|---|
| **AVAMERE REHABILITATION AT FIESTA PARK** | **8820 HORIZON BOULEVARD NE ALBUQUERQUE, NM 87113** |

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<br><br>**Level of harm -** Actual harm<br><br>**Residents Affected -** Few | **Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on record review and interview the facility failed to ensure 1 (R#1) of 5 (R #1, 2, 3, 4 and 5) residents who were reviewed for receiving wound care and treatment was free from neglect, when the facility delayed providing wound care and treatment for 11 days, between which new multiple pressure wounds were identified by the hospice nurse and from when new orders for treatment were initiated. This deficient practice likely resulted in worsening pressure wounds for R #1. The findings are: A. Record review of R#1 facesheet indicates he was admitted to the facility on [DATE] with the following Diagnoses: [REDACTED]. Record review of R #1 care plan initiated 12/24/19 reveals that R #1 is at risk for skin impairment or has actual skin impairment with goals and intervention. C. Record review of physician orders dated 02/07/20 reveals R#1 was admitted to hospice care (end of life care) with a [DIAGNOSES REDACTED]. D. Record review of physician orders dated 02/07/20 reveal Please call (Name of Hospice Care Provider) for all changes in condition, any new orders, lab draws, X-rays, diagnostic needs, or for any questions or concerns. E. Record review of Hospice Care Nurse (HCN) #1 narrative dated 03/27/20 reveals the following was able to gain access to facility amid Covid 19 outbreak. Patient (R#1) has significantly delcined. .Patient has multiple skin tears to BUE (Bilateral Upper Extremities) . motteling (patchy irregular colored skin. Generally recognized as an end of life condition) present to bilateral (both) knees .Patient is completely bedbound, incontinent (uncontrolled illimination of urine and feces) of B/B (bowel and bladder) . at peace with his decline. F. Record review of R#1 weekly skin check dated 03/30/20 reveals a notation of an irregularity of the right heal described as a redness. No other wounds or irregularities are described. G. Record review of R#1's daily care-personal hygiene dated 03/01/20 to 04/30/20 reveals that facility staff provided daily care for personal hygiene with one to two person assist. H. Record review of Hospice Care Nurse (HCN) #1 narrative dated 04/03/20 reveals that HCN#1 arrived at the facility and found R#1 in bed: . Patient (R#1) was found to have significant breakdown on his body (referring to an unidentified pressure ulcer). Patient (R#1) brief (Adult diaper) was on so tight there was breakdown along the waist line. Patient has a very large Stage Two pressure ulcer (a shallow, partial thickness, skin rupture that does not penetrate to the fatty tissue below the surface) to sacrum/coccyx (lower back just above the buttocks). Patient has feces caked on his bottom. (Name of hospice aide) and myself cleansed area thoroughly. Seal barrier cream was placed. Patient has 3 stage 1 pressure ulcers to his back. R (right) fifth rib has an area where blood has pooled due to patient not being turned .I (HCN#1) notified (first name only of Facility Nurse) FN#1 of patients poor skin conditions. I. Record review of physician orders dated on or about 04/03/20 reveal no order for treatment of [REDACTED].#1 on 04/03/20. J. Record review of Treatment Administration Record (TAR) date April 2020 reveals no treatment of [REDACTED]. K. Record review of Daily Notes indicates there is no notation entered on 04/03/20 acknowledging the presence of any new pressure ulcers. L. Record review of Daily Notes dated 04/04/20 makes no notation of any skin damage. The notation indicates R#1 is incontinent (unable to control bowel or bladder) and that incontinence care is being provided per protocol. An adult brief is being utilized and pericare (cleansing and care provided to the groin area) is provided. M. Record review of hospice care daily notes dated 04/07/20 by HCN #2 reveals a notation of a large wound to the coccyx (tail bone-bony prominence just above the buttocks) which she cleaned and covered, there is no indications that this information and treatment was conveyed to any member of the facility staff. N. Record review of Daily Notes dated 04/07/20 makes no notation of any skin damage. The notation indicates R#1 is incontinent and that incontinence care is being provided per protocol. An adult brief is being utilized and pericare is provided. O. Record review of Weekly Skin Check dated 04/14/20 reveals an irregularity that is described as 15x13 centimeters (cm) open area, edges not approximated (joined), granulation tissue (scar tissue) noted, serosanguinous (a bodily fluid composed of blood and clear liquids) drainage noted. P. Record review of R#1's Treatment Administration Record dated April 2020 reveals that on 04/14/20 staff began treatment of [REDACTED]. Q. Record review of R#1 daily nursing notes indicate that on 04/29/20 R#1 became non-responsive. His death was pronounced at 3:47 am. R. On 05/08/20 at 3:30 pm during interview with HCN #1 stated that she conducted a hospice visit with R#1 on 04/03/20. She confirmed that on entering his room she found that R#1 was unkempt and needed bathing and cleaning. She stated that she did this and found the described wounds. HCN#1 stated that following care, she told FN#1of the wounds she found to R#1's back and coccyx. S. On 05/21/20 at 1:50 pm during interview with Certified Nurses Aide (CNA) #1, she stated that she has worked for the facility for four year. She stated that facility CNA's do daily care for all residents including the hospice residents and that this care includes personal care, repositioning and assisted dining. She states that showers are usually done by hospice CNAs who come 3 times per week to provide shower care. CNA#1 stated that if a hospice resident requires a shower between hospice visits then staff would certainly provide such care. T. On 05/22/20 at 2:03 pm during interview with DON, she stated that residents who are on hospice have their care managed by the hospice doctor and that all daily care is managed by the facility nursing staff while the hospice nurses conduct regular visits to monitor resident care. She confirmed that any changes in condition of a resident should be reported by the facility staff to either the hospice nurse or the hospice doctor for orders and follow-up. She stated that their hospice residents have a communication book at the bedside for the hospice nurses to comment on care and needs of residents following their visits. She was unable to produce any such book for R#1 and suggested that it was probably gathered by the hospice care nurses after R#1 passed away. DON stated that both the hospice nurses and the staff nurse should have reported the identified wound on 04/03/20 and treatment should have begun immediately. She also confirmed that any such order for care should have been entered by either the hospice nurse DON confirmed that no physician orders were entered until 04/14/20 and there appears to have been on treatment of [REDACTED]. |
| F 0657<br><br>**Level of harm -** Minimal harm or potential for actual harm<br><br>**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.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on record review and interview, the facility failed to update care plans for 1 (R#1) of 1 (R#1) residents reviewed for care planning of wound care. This deficient practice likely resulted in the resident's care plan not being updated to indicate changes in condition and care. A. Record review of R #1 Treatment Administration Record (TAR) dated April 2020 reveals ongoing treatment of [REDACTED]. B. Record review of R #1 care plan initiated 12/24/19 which reveals that R #1 is at risk for skin impairment or has actual skin impairment with goals and intervention. There is no noted update on or about 04/14/20 to include sacral skin damage treatment, goals or interventions. C. On 05/22/20 at 2:03 pm during interview with Director of Nursing (DON) she reviewed R#1's care plan and confirmed that his care plan should have been updated on or about 04/14/20 to include the skin damage to the sacral area. |

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 0657<br><br>**Level of harm -** Minimal harm or potential for actual harm<br><br>**Residents Affected -** Few | (continued... from page 1) |
| F 0658<br><br>**Level of harm -** Minimal harm or potential for actual harm<br><br>**Residents Affected -** Few | **Ensure services provided by the nursing facility meet professional standards of quality.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on record review and interview, the facility failed to meet professional standards of quality for 1 (R #2) of 1 (R #2) residents reviewed for ongoing skin checks failed to follow physician's orders [REDACTED]. If the facility is not performing weekly skin and wound evaluations, then residents are not likely to receive the care and/or services they deserve and need. The findings are: A. Record review of R #2's physician orders [REDACTED]. B. Record review of R #2's Skin and Wound Evaluation V5 reveals an assessment was performed and documented on the dates of Tuesday 05/06/20 and Thursday 05/21/20. No other Skin and Wound Evaluation V5 were present in R #2's electronic health record. C. On 05/22/20 at 2:02 pm during an interview with the Director of Nursing (DON), when asked about missing weekly skin and wound evaluations, DON confirmed weekly skin and wound evaluations were not being performed for R #2. DON stated, It (weekly skin and wound evaluations) should be done every week and it's not. |