STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	325125	A. Building B. Wing	10/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bear Canyon Rehabilitation Center	5123 Juan Tabo Boulevard NE Albuquerque, NM 87111

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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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. 35632 Based on record review and interview, the facility failed to notify the family member/Power of Attorney (POA; a power of attorney grants, in writing, a particular agent the power to make healthcare decisions on another's behalf) for 1 (R #5) of 3 (R #5, #6 and #7) residents when a resident began to decline, consistently refuse medications, and was not eating or drinking. If the facility is not notifying the resident's POA when the resident has a change of condition, then the POA is unable to make decisions related to treatment and advocate for the resident's care. The findings are: A. Record review of a nursing progress note for R #5, dated 06/11/24, indicated the resident refused all the medications, and she kept saying, I don't want it. The resident put her hands against her face/mouth and pushed away the medications when when staff attempted to administered them. B. Record review of a nursing progress note for R #5, dated 06/11/24, revealed the facility nurse (unidentified) spoke with the hospice nurse and informed the hopsice nurse that R #5 spat out medications and experienced excessive crying and agitation. Facility staff requested to have medication in liquid form. C. Record review of a nursing progress note for R #5, dated 06/12/24, indicated the resident cried out for help and refused medications. Hospice to call in order for haloperidol (medication used to treat a range of disruptive disorders, behavior problems, and motion problems), intermuscular (between muscle), and all other medications in liquid form. D. Record review of the nursing progress notes for R #5, dated 06/14/24, indicated R #5 refused most medications, except for gabapentin (medication for nerve pain), but she drank some water and juice with assistance. Hospice updated on refusals. E. Record review of the nursing progress notes for R #5, dated 06/05/24 through 06/17/24, the records did not contain any documentation staff notified the brother/POA when R #5 began to decline and refused to eat and to take medications. F. On 10/08/24 at 10:25 am, during an interview with the Director of Nursing (DON), she stated she did not see any documentation in R #5's medical chart to indicate staff notified the resident's brother/POA when R #5 started to refuse medications and did not want to eat and drink anything on 06/14/24 and 06/15/2. She stated staff should have notified the POA of these changes. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	G. On 10/08/24 at 12:24 pm, during an interview with R #5's brother/POA, he stated hospice services started for his sister, R #5, on 06/04/24. He stated he signed the paperwork for R #5 to receive hospice services on 06/03/24. He stated he did not hear from the hospice company or the facility after hospice services started. He stated that he found out about his sister's condition when a friend called him on 06/17/24. He stated his friend told him R #5 did not look good, and he was not sure she would make it through the night. The POA stated that was when he found out about his sister's decline, that she refused medications, and she was not eating and drinking. POA/brother asked for his sister (R #5) to be sent to the hospital during the conversation he had with the facility nurse on 06/17/24.

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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 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident’s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35632 Based on record review and interview the facility failed to provide quality of care for 1 (R #5) of 3 (R #5, 6, and 7) residents reviewed when they failed to: 1. Identify a change in condition for seven days, 2. Notify the Physician and Power of Attorney (POA; someone to make decisions for you when you are no longer to make them) of the decline, 3. Assess for the cause of the decline and provide treatment, 4. Send the resident to the hospital and waited 15 hours after the request by the POA. This deficient practice likely resulted in further decline for R #5 and a delay in providing life saving treatment. The findings are: A. Record review of R #5's face sheet indicated R #5 was originally admitted to the facility on [DATE] with the following diagnoses: - Multiple sclerosis [a potentially disabling disease of the brain and spinal cord (central nervous system)], - Trigeminal neuralgia (a chronic pain disorder that causes intense pain attacks in your face), - Neuromuscular dysfunction of the bladder (condition that affects bladder function due to nervous system injury or disease), - Suprapubic catheter (tube that is inserted into your abdomen to drain urine), - Antibiotic resistance, - Methicillin resistant staphyloccus aureus infection (MRSA; a staph bacteria that is resistant to many antibiotics), - Bacteremia (bacteria in the blood), - Metabolic encephalopathy (a change in brain function due to an underlying cause), - Severe sepsis with septic shock (life-threatening condition that arises when the body's response to infection causes injury to its own tissues and organs), - Acute kidney failure (an abrupt reduction in kidneys' ability to filter waste products occurs within a few hours or a few days), - Dysphagia (difficulty swallowing foods and liquids), (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	- Protein calorie malnutrition (not enough calories). - This is not an all inclusive list. B. Record review of the hospice's consult form for R #5, dated [DATE], indicated R #5 accepted hospice on [DATE] with a diagnosis of multiple sclerosis. C. Record review of a sepsis assessment for R #5, dated [DATE], indicated the following: - For Question #3, Neurological, staff documented the following: - Is there slow mental status? Yes. - Are there any new or worsening confusion? Yes. - Is there any new/worsening confusion? Yes. - Is there any new/worsening agitation? Yes. - For Question #4, Plan, staff documented the following: - Were positive findings identified (any two positive vital signs or any one system finding present)? Yes . - Current diagnosis and/or history of sepsis? Yes. - Type of follow-up needed? Every six hours. Positive finding and/or practitioner recommendation. D. Record review of the nursing progress notes for R #5 revealed the following: - Dated [DATE] at 3:16 pm, R #5 refused medications and stated, I don't want it. The resident put her hands against her face/mouth and attempted to push away the medication when staff tried to administer it. Hospice made aware. The note did not indicate if staff notified the POA or hospice physician. - Dated [DATE] at 12:59 am, R #5 was crying, called out for help, and refused her medications. Hospice nurse to order Haloperidol (an anitpsychotic medication) intramuscularly (IM) and all other medications in liquid form. The note did not indicate if staff notified the POA or hospice. - Dated [DATE] at 5:38 pm, Hospice nurse and Certified Nursing Assistant saw R #5. R #5 was responding verbally. The resident was able to mention her name softly when staff asked. The resident refused all medications except Gabapentin (medication to treat seizures and pain) and drank two cups of water with staff assistance. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	- Dated [DATE] at 3:36 pm, R #5 was not eating or taking medication. The hospice nurse was in the facility when R #5's POA called the facility. The POA stated he no longer wanted his sister (R #5) to be on hospice when staff informed him of R #5's declining status. Facility staff stated they would send him a new advanced directive form (a legal document to provide instructions for medical care that goes into effect when an individual cannot communicate their wishes), and he needed to fill it out and send it back. The note revealed R #5 would remain on hospice services and would remain a Do Not Resuscitate (DNR; lifesaving measures are not desired) until the facility received the Medical Orders for Scope of Treatment (MOST; a legal document which outlines the care the resident wants when they become incapacitated and unable to speak for themselves) form back indicating the new interventions. The note did not indicate if staff notified the hospice physician. - Dated [DATE] at 4:09 pm, R #5's vital signs were ,d+[DATE] blood pressure (BP; normal is ,d+[DATE]), 97. 8 degrees ( ) Fahrenheit (F) temperature (98.6 F is normal), 80 pulse (normal is 60 to 100), 92 percent (%) oxygen saturation (the amount of oxygen in the blood. Normal is in the 90%s) on 2 liters (L) of oxygen, 17 breaths per minute (bpm; normal is 12 to 20). - Dated [DATE] at 10:51 pm, the Director of Nursing (DON) contacted Nurse #1, who was working at the facility with R #5 that evening. The DON told the nurse if the family wanted R #5 sent to the hospital then the resident needed to be sent to the hospital. Nurse #1 contacted the ambulance company and requested a transport for R #5. The ambulance dispatch asked why R #5 needed to be transported to the hospital. Nurse #1 told the ambulance dispatch the family requested for the resident to go, and R #5 was on hospice. Nurse #1 explained multiple times to the ambulance dispatch the family requested the transport. Nurse #1 stated she would contact the DON to see if she could explain it to the ambulance dispatch so they would better understand why R #5 needed to go to the hospital. Nurse #1 also called a different ambulance service, but they requested insurance paperwork and information. Nurse #1 waited for a response from the DON on the transport. - Dated [DATE] at 6:53 am, the dayshift nurse, Nurse #2, called the ambulance again to have R #5 picked up and taken to the hospital. Nurse #2 completed an assessment on R #5 and the resident's vitals were: blood pressure ,d+[DATE], pulse 49, respirations 10, temperature 99.9 F, and oxygen saturation 79%. Staff turned up R #5's oxygen administration to 4 liters per minute, and the resident's oxygen saturation went up to 96 %. R #5' urine output was 50 cubic centimeter (cc) and was dark. E. Record review of the hospital's documentation for R #5 indicated the following: - R #5 arrived to the hospital on [DATE]. - R #5 was unresponsive at her facility that morning, [DATE]. - Once in the emergency department, R #5 was noted to be hypotensive (low blood pressure), bradypneic (abnormally slow breathing rate), was subsequently intubated (a tube is inserted into trachea to help breathe), and started on vasopressors (help raise blood pressure when the blood pressure is so low that enough blood cannot get to the organs). - Computed tomography (CT; uses several X-ray images and computer processing to create cross sectional images) was consistent with bilateral lower lobe atelectasis (the collapse of the lower parts of both lungs). (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	- CT scan of abdomen/pelvis with stercoral colitis (abdominal pain, abdominal distension, constipation, nausea and/or vomiting, and loss of appetite) with cystitis (infection or inflammation of the urinary bladder caused by bacteria). - Other significant findings included metabolic acidosis (acids build up in the body due to poor kidney function) and acute kidney injury (AKI; when the kidneys cannot filter waste products from the blood) with oliguria (low urine output). - R #5 was admitted to medical intensive care unit (MICU) for further work up and management. - Critical Care Attestation indicated ongoing acute issues continued to contribute to current critical state. At time of evaluation, patient was critically ill and had a high probablity of imminent lift or limb threatening deterioration due to acute central nervous system compromise and respiratory failure. To stabilize critical patient, support vital functions, and prevent further decline, bedside assessment was completed to include interpreting cardiac monitoring and resuscitating the patient with mechanical ventilator mangement. F. On [DATE] at 12:24 pm, during an interview with R #5's brother/POA, he stated they told his sister when they offered hospice services that they would be able to offer more care for her, and they told him the same thing. He stated he signed the paperwork. The POA stated he received a call from a friend a couple of weeks later. The friend had gone to the facility and saw R #5 on [DATE]. The POA stated his friend told him that R #5 looked awful and did not seem like she was going to make it through the day. The POA stated that was when he called the facility and spoke with the nurse. The POA stated staff told him R #5 was on hospice care, and she was a DNR status. The POA stated the staff told him the interventions were limited unless he no longer wanted hospice. The POA stated staff told him he would need to change R #5's code status for interventions, The POA stated he wanted to change R #5's code status, and he wanted his sister to go to the hospital. He stated he also spoke with hospice and told them the same thing. He stated he wanted his sister's code status changed, he wanted his sister to go out to the hospital, and he no longer wanted hospice services. He stated there was a delay in getting his sister sent to the hospital, and she did not go out until the next day. G. On [DATE] at 9:00 am, during an interview with R #5, she stated she thought she would get more of her needs met when she went on hospice. She stated she agreed to go on hospice. R #5 stated she did not feel like anyone listened to her and like she got less care on hospice. R #5 stated that she was pretty out of it before she was sent to the hospital on [DATE] so she did not remember a lot of what happened. She stated that she almost died . She stated she was a full code status (life saving interventions desired) and not on hospice since she returned from the hospital. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	H. On [DATE] at 11:30 am, during an interview with the DON, she stated she spoke with one of the hospice providers on [DATE], and she thought it was the Hospice DON. The DON stated the hospice staff told her hospice was fine with sending R #5 out to the hospital. The DON called Nurse #1 on [DATE] and told her to send R #5 to the hospital, because that was what the family wanted. The DON could not recall the exact time she spoke to Nurse #1, but stated it was later in the day. The DON stated Nurse #1 called Emergency Services Dispatch on [DATE], and the dispatch staff asked why R #5 needed to go to the hospital. Nurse #1 told dispatch staff that the family requested the resident to be sent out. The DON said she received another call from Nurse #1, because she was concerned she did not have the resident's new/updated MOST form. The DON told Nurse #1 that R #5's brother verbally stated he wanted R #5 to be sent to the hospital and wanted her to be a full code; therefore, the facility needed to follow those wishes. The DON said Nurse #1 called Emergency Services Dispatch to tell them that R #5 was a full code, and the family wanted her to be sent out. The DON stated the Emergency Services Dispatch told Nurse #1 that they would come pick the resident up when they could, because it was not an emergency. The DON stated Nurse #2 completed an assessment on R #5 during the morning shift on [DATE] and found R #5 was declining. The DON stated the resident's vitals indicated she was very close to dying. Nurse #2 called Emergency Services Dispatch again to take R #1 to the hospital due to her condition was an emergency. The DON stated R #5's decline was expected. She stated did not keep R #5's brother/POA informed of the resident's decline, because he was not that involved in R #5's care.