| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 325071 | A. Building<br>B. Wing | 12/18/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Aztec Healthcare | 500 Care Lane<br>Aztec, NM 87410 |

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 0580<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>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.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** PAST NOT COMPLIANCE<br><br>Based on record review and interview, the facility failed to notify the physician, for 1 (R #7) of 1 (R #7) resident reviewed, of the results of the resident's ordered chest X-ray, complete blood count (CBC; a blood test that measures the number and type of cells in the blood), and comprehensive metabolic panel (CMP; a group of tests to measure various substances in the blood) following a change in condition. This deficient practice likely resulted in delayed treatment for pneumonia (a lung infection that makes it difficult for a person to breathe) and likely contributed to R #7's death. The findings are:<br><br>A. Record review of R #7's hospital discharge report, dated 10/31/24, revealed R #7 was a [AGE] year old male with history of liver cirrhosis (chronic liver damage leading to scarring and liver failure), esophageal varices (abnormal veins that usually develop when the blood to the liver is blocked) and chronic left arm deformity, presenting with concern for gastrointestinal (GI; digestive tract) bleed. He initially presented with confusion, falls, and weakness. He was given cefepime (antibiotic) and vancomycin (antibiotic) for possible pneumonia.<br><br>B. Record review of R #7's facility Face Sheet revealed the resident was admitted to the facility on [DATE].<br><br>C. Record review of R #7's care plan, dated 11/01/24, revealed R #7 had an advanced directive of Full Code (life saving procedures desired.)<br><br>D. Record review of R #7's Medication Administration Record, dated November 2024, revealed R #7 was prescribed and received the following medications:<br><br>1. Furosemide (a diuretic, water pill; medication to help the kidneys remove extra salt and water through urine) 20 mg daily,<br><br>2. Pantoprazole (medication used to reduced stomach acid) 40 mg daily for gastroesophageal reflux disease (GERD; A digestive disease in which stomach acid or bile irritates the food pipe lining),<br><br>3. Lactulose (laxative) 10 grams (g) / 15 milliliters (ml) three times daily for constipation,<br><br>4. Midodrine (medication used to treat low blood pressure) 5 mg three times daily for orthostatic hypotension (low blood pressure.)<br><br>(continued on next page) |

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.

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

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 325071 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 12/18/2024 |
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| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Aztec Healthcare | 500 Care Lane<br>Aztec, NM 87410 |

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| F 0580<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | E. Record review of R #7's change in condition (CIC) assessment, dated 11/26/24, revealed staff reported the resident experienced a change in medical condition due to constant unproductive cough that started at midnight. Staff documented, I heard the resident persistent coughing, unproductive cough, weak. Staff notified the Medical Provider at 5:00 am, and the Medical Provider ordered the resident to be sent to the hospital for a chest x-ray, CBC, CMP, and Robitussin (cough medicine) 10 ml every four hours as needed.<br><br>F. Record review of R #7's diagnostic results of the X-ray, CBC, and CMP revealed the results were faxed to the facility on [DATE] at 1:52 PM. The lab results included the following:<br><br>1. Red blood cell count: 2.37 (normal 4.30 to 5.90),<br><br>2. Hemoglobin: 8.4 (normal 13.9 to 17.5),<br><br>3. Hematocrit: 25.2 (normal 41.0 to 53.0),<br><br>4. Sodium: 124 (normal 137 to 145),<br><br>5. Potassium: 2.8 (normal 3.5 to 5.1),<br><br>6. Chloride: 95 (normal 98 to 107),<br><br>7. Chest x-ray: Small infusions with basilar (build-up of fluid between lungs and diaphragm) predominant airspace opacities (gray area of lungs.) Worse compared to 11/03/24.<br><br>G. Record review of Staff Member (SM) #1's written statement revealed SM #1 received the lab results on 11/26/24 at 1:53 PM and emailed the results to the Director of Nursing (DON) and the Assistant Director of Nursing (ADON) on 11/26/24 at 1:58 PM. SM #1 also printed a hard copy of the results and left it at the nurse's station.<br><br>H. Record review of R #7's medical record revealed there were not any new orders for the resident from 11/26/24 to 11/28/24.<br><br>I. Record review of R #7's CIC assessment, dated 11/28/24, revealed staff reported a CIC due to expiratory wheezing (a whistling sound that occurs when you exhale and indicates a partial or mild blockage in your airway. It is often caused by a narrowing of the smaller airways). The physician was notified on 11/28/24 at 3:36 pm, and it was recommended that R #7 get a chest x-ray.<br><br>J. On 12/16/24 at 3:29 PM during an interview, the ADON stated R #7 was sent for labs and a chest x-ray on 11/26/24 due to persistent and unproductive cough. She stated the lab results and chest x-ray were faxed to the facility on the same day (11/26/24), and the receptionist was responsible to get the labs to the staff. The ADON stated the lab results were left on the keyboard at the nurse's station on 11/26/24. She stated she [ADON] should have sent the lab results to the Physician on 11/26/24, but she did not. The ADON stated staff should have notified the resident's physician the same day regarding the abnormal lab results, but they did not. The ADON reviewed the R #7's lab results and stated R #7's potassium was critically low. She stated R #7 should have been sent to the hospital since he was on a lasix (furosemide) and did not have a potassium supplement ordered. The ADON stated the physician ordered the resident to be sent out for a chest x-ray after the CIC on 11/28/24; however, staff noted an x-ray was done on 11/26/24, but the labs needed to be reviewed. The ADON stated<br><br>(continued on next page) |

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| NAME OF PROVIDER OR SUPPLIER Aztec Healthcare | | STREET ADDRESS, CITY, STATE, ZIP CODE 500 Care Lane Aztec, NM 87410 | |

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| F 0580<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | staff notified the Physician on 11/29/24 of the resident's x-ray results from 11/26/24. The ADON stated the Physician suspected R #7 had pneumonia and ordered Levaquin (an antibiotic.)<br><br>K. Record review of R #7's Medication Administration Record revealed an order, started on 11/29/24, for Levaquin 250 mg. Give two tablets by mouth one time a day for infection for 10 days.<br><br>L. Record review of R #7's nursing progress notes, dated 11/30/24, revealed staff found the resident unresponsive and breathless on 11/30/24 at 12:53 AM. R #7 was unable to be revived despite emergency care including cardiopulmonary resuscitation (CPR; an emergency procedure that combines chest compression with artificial ventilation). R #7 passed away.<br><br>M. On 12/17/24 at 1:40 PM during an interview, R #7's Physician stated staff did not notify him of the x-ray results and blood test results that were ordered on 11/26/24. The Physician stated if staff had notified him, then he would have ordered antibiotics to treat R #7's pneumonia. He confirmed staff did not notify him of the abnormal potassium results. He stated he also would have ordered a potassium supplement and follow-up testing for the low potassium. He stated staff notified him of the chest x-ray results from 11/26/24 which showed the resident had pneumonia, and he ordered Levaquin. The Physician stated R #7's death was not unexpected, and he should have been on palliative care (specialized medical care for people living with a serious or chronic illness.)<br><br>Based upon record review and interview, the incident was identified as Past Non-Compliance (PNC) Immediate Jeopardy (IJ). The facility Administrator was notified of the IJ on 12/17/24 at 3:55 pm.<br><br>Based on the facility's investigation of R #7's death, the following interventions were implemented and placed in an Improvement Action Plan prior to survey investigation which included:<br><br>Facility sweep of residents with diagnostic orders and verify physician notification. Completed 12/01/24.<br><br>- No residents were identified as having non-compliance.<br><br>Staff education on appropriate follow-up/notification of lab results. Completed 11/30/24.<br><br>- Record review of In-service training report, dated 11/30/24, revealed a summary of training to include ensuring Change of Condition (COC) assessments and reporting, inputting admission orders and progress notes, complete lab tracking sheet at the end of the shift, and reporting lab and imaging results to MD. The training was signed by ten nurses (RN/LPNs) and one CNA.<br><br>Process changes for delivery of diagnostic results to include face-to-face receipt of results. Completed 11/30/24.<br><br>- On 12/17/24 at 8:50 am during interview with the Director of Nursing (DON), she confirmed the process for diagnostic results delivery was changed to include a hot handoff (receptionist must physically hand the results to a nurse). The DON also confirmed they have added a tracker and auditing book to monitor results.<br><br>Implementation of new tracking for diagnostic orders. Completed 11/30/24.<br><br>- On 12/17/24 at 8:50 am during interview with the DON, she confirmed they added a tracker and<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 325071 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 12/18/2024 |
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| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Aztec Healthcare | 500 Care Lane<br>Aztec, NM 87410 |

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 0580<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | auditing book to monitor results.<br><br>- Record review of the tracker revealed sections to include date of COC, lab tracker with drawn and result dates, and Physician notification.<br><br>Ad Hoc QAPI meeting to discuss and approve Improvement Action Plan. Completed 12/03/24.<br><br>Continuing audits reported at QAPI meetings. On-going.<br><br>Surveyor verified the implementation of the Improvement Action Plan and did not identify any further non-compliance with samples residents. |

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| F 0684<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Provide appropriate treatment and care according to orders, resident's preferences and goals.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** PAST NON-COMPLIANCE<br><br>Based on record review and interview, the facility failed to notify the physician, for 1 (R #7) of 1 (R #7) resident reviewed, of the results of the resident's ordered chest X-ray, complete blood count (CBC; a blood test that measures the number and type of cells in the blood), and comprehensive metabolic panel (CMP; a group of tests to measure various substances in the blood) following a change in condition. This deficient practice likely resulted in delayed treatment for pneumonia (a lung infection that makes it difficult for a person to breathe) and likely contributed to R #7's death. The findings are:<br><br>A. Record review of R #7's hospital discharge report, dated 10/31/24, revealed R #7 was a [AGE] year old male with history of liver cirrhosis (chronic liver damage leading to scarring and liver failure), esophageal varices (abnormal veins that usually develop when the blood to the liver is blocked) and chronic left arm deformity, presenting with concern for gastrointestinal (GI; digestive tract) bleed. He initially presented with confusion, falls, and weakness. He was given cefepime (antibiotic) and vancomycin (antibiotic) for possible pneumonia.<br><br>B. Record review of R #7's facility Face Sheet revealed the resident was admitted to the facility on [DATE].<br><br>C. Record review of R #7's care plan, dated 11/01/24, revealed R #7 had an advanced directive of Full Code (life saving procedures desired.)<br><br>D. Record review of R #7's Medication Administration Record, dated November 2024, revealed R #7 was prescribed and received the following medications:<br><br>1. Furosemide (a diuretic, water pill; medication to help the kidneys remove extra salt and water through urine) 20 mg daily,<br><br>2. Pantoprazole (medication used to reduced stomach acid) 40 mg daily for gastroesophageal reflux disease (GERD; A digestive disease in which stomach acid or bile irritates the food pipe lining),<br><br>3. Lactulose (laxative) 10 grams (g) / 15 milliliters (ml) three times daily for constipation,<br><br>4. Midodrine (medication used to treat low blood pressure) 5 mg three times daily for orthostatic hypotension (low blood pressure.)<br><br>E. Record review of R #7's change in condition (CIC) assessment, dated 11/26/24, revealed staff reported the resident experienced a change in medical condition due to constant unproductive cough that started at midnight. Staff documented, I heard the resident persistent coughing, unproductive cough, weak. Staff notified the Medical Provider at 5:00 am, and the Medical Provider ordered the resident to be sent to the hospital for a chest x-ray, CBC, CMP, and Robitussin (cough medicine) 10 ml every four hours as needed.<br><br>F. Record review of R #7's diagnostic results of the X-ray, CBC, and CMP revealed the results were faxed to the facility on [DATE] at 1:52 PM. The lab results included the following:<br><br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | M. On 12/17/24 at 1:40 PM during an interview, R #7's Physician stated staff did not notify him of the x-ray results and blood test results that were ordered on 11/26/24. The Physician stated if staff had notified him, then he would have ordered antibiotics to treat R #7's pneumonia. He confirmed staff did not notify him of the abnormal potassium results. He stated he also would have ordered a potassium supplement and follow-up testing for the low potassium. He stated staff notified him of the chest x-ray results from 11/26/24 which showed the resident had pneumonia, and he ordered Levaquin. The Physician stated R #7's death was not unexpected, and he should have been on palliative care (specialized medical care for people living with a serious or chronic illness.)<br><br>Based upon record review and interview, the incident was identified as Past Non-Compliance (PNC) Immediate Jeopardy (IJ). The facility Administrator was notified of the IJ on 12/17/24 at 3:55 pm.<br><br>Based on the facility's investigation of R #7's death, the following interventions were implemented and placed in an Improvement Action Plan prior to survey investigation which included:<br><br>Facility sweep of residents with diagnostic orders and verify physician notification. Completed 12/01/24.<br><br>- No residents were identified as having non-compliance.<br><br>Staff education on appropriate follow-up/notification of lab results. Completed 11/30/24.<br><br>- Record review of In-service training report, dated 11/30/24, revealed a summary of training to include ensuring Change of Condition (COC) assessments and reporting, inputting admission orders and progress notes, complete lab tracking sheet at the end of the shift, and reporting lab and imaging results to MD. The training was signed by ten nurses (RN/LPNs) and one CNA.<br><br>Process changes for delivery of diagnostic results to include face-to-face receipt of results. Completed 11/30/24.<br><br>- On 12/17/24 at 8:50 am during interview with the Director of Nursing (DON), she confirmed the process for diagnostic results delivery was changed to include a hot handoff (receptionist must physically hand the results to a nurse). The DON also confirmed they have added a tracker and auditing book to monitor results.<br><br>Implementation of new tracking for diagnostic orders. Completed 11/30/24.<br><br>- On 12/17/24 at 8:50 am during interview with the DON, she confirmed they added a tracker and auditing book to monitor results.<br><br>- Record review of the tracker revealed sections to include date of COC, lab tracker with drawn and result dates, and Physician notification.<br><br>Ad Hoc QAPI meeting to discuss and approve Improvement Action Plan. Completed 12/03/24.<br><br>Continuing audits reported at QAPI meetings. On-going.<br><br>Surveyor verified the implementation of the Improvement Action Plan and did not identify any further non-compliance with samples residents. |