STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	325043	A. Building B. Wing	08/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Casa Arena Healthcare LLC	205 Moonglow Alamogordo, NM 88310

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41755 Based on record review and interview, the facility failed to develop an accurate, person-centered comprehensive care plan for 2 (R #2 and R #21) of 5 (R #1, R #2, R #3, R #21, and R #22) residents reviewed for care plans. This deficient practice could likely result in staff being unaware of the current and actual needs of the residents. The findings are: R #2 A. Record review of R #2's Admission Record (no date) revealed the following 1. R #2 was admitted to the facility on [DATE]. 2. R #2 diagnoses is as follows: a. bipolar disorder (serious mental illness characterized by extreme mood swings, that can include extreme excitement episodes or extreme depressive feelings) b. depression (mood disorder that causes a persistent feeling of sadness and loss of interest). B. Record review of R #2's Care Plan dated 05/23/24 revealed the following: 1. R #2 has a behavior problem r/t (related to) anxiety (an emotion characterized by feelings of tension, worried thoughts, and physical changes like increased blood pressure)/bipolar schizophrenia (mental disorder characterized by delusions, hallucinations, disorganized thoughts, speech and behavior). 2. R #2 displays feelings of sadness and depression as characterized by a lack of acceptance to current condition and to return home. C. Record review of R #2's history and physical (H & P; comprehensive formal assessment by a healthcare provider that includes a thorough health history and physical examination) dated 05/24/24 revealed the following: 1. bipolar disorder onset 04/06/24 (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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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. depressive disorder onset 10/03/17 3. Diagnosis of Schizophrenia was not included in the history and physical form. D. On 08/21/24 at 2:46 PM, during an interview with the DON, she confirmed that R #2's Admission Record and H & P assessment did not include a diagnosis of schizophrenia. The DON also stated that residents usually take medication to treat schizophrenia and R #2 does not take schizophrenia type of medication. R #21 E. Record review of R #21's Admission Record (no date) revealed R #21 was admitted on [DATE]. F. Record review of R #21's admission Minimum Data Set Assessment (MDS, part of the U.S. federally mandated process for clinical assessment of all residents in Medicare or Medicaid-certified nursing homes. It is a core set of screening, clinical and functional status elements, including common definitions and coding categories, which forms the foundation of a comprehensive assessment), dated 04/24/24, revealed the following functional abilities: 1. Eating: R #21 required partial/moderate assistance (Helper does less than half the effort). 2. Toileting hygiene: R #21 required substantial/maximal assistance (Helper does more than half the effort). 3. Shower/bathe self: R #21 required substantial/maximal assistance. 4. Roll left and right: R #21 required substantial/maximal assistance. 5. Chair/bed-to-chair transfer: R #21 required substantial/maximal assistance. 6. Toilet transfer: R #21 required substantial/maximal assistance. 7. Tub/shower transfer: R #21 required substantial/maximal assistance. 8. Walk 10 feet: R #21 required substantial/maximal assistance. G. Record review of R #21's care plan, dated 04/23/24, revealed the care plan did not address R #21's functional abilities. H. On 8/21/24 at 1:46 PM, during an interview with the MDS Coordinator, he confirmed the following: 1. R #21's care plan did not include R #21's functional abilities. 2. MDS coordinator completes the comprehensive care plan. 3. Functional abilities should be included in the resident's care plan after completion of the admission MDS. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	49313

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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 0657 Level of Harm - Minimal harm or potential for actual harm 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49313 Based on record review and interview, the facility failed to ensure care plan revision occurred for 1 (R #21) of 3 (R #1, R #21, and R #22) residents reviewed for care plans, when they failed to update R #21's care plan after he fell . This deficient practice could likely result in the care plan not being updated with the most current resident conditions and appropriate interventions, staff being unaware of changes in care provided, and residents not receiving the care related to changes in their health status or healthcare decisions. The findings are: A. Record review of R #21's medical record revealed R #21 was admitted on [DATE]. B. Record review of R #21's progress notes, dated 05/05/24, revealed R #21 fell in the bathroom. C. Record review of R #21's care plan, dated 04/23/24, revealed the following: 1. R #21 was a high risk for falls. 2. Staff did not revise R #21's care plan to include R #21's fall on 05/05/24. 3. Staff did revise R #21's care plan to include interventions to prevent R #21 from falling again. D. On 8/21/24 at 1:46 PM, during an interview with the MDS Coordinator, he confirmed the following: 1. R #21 fell on [DATE]. 2. R #21's care plan did not include R #21's fall on 05/05/24. 3. R #21's care plan did not include any interventions to prevent R #21 from falling in the future. 4. R #21's care plan should have been revised after he fell on [DATE], to included interventions to prevent him from falling in the future. 5. The DON or MDS coordinator are supposed to complete care plan revisions after falls.