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	03/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Casa Arena Healthcare LLC	205 Moonglow Avenue 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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to report allegations of misappropriation of resident property (the deliberate misplacement, exploitation, or wrongful, temporary, or permanent use of a resident's belongings or money without the resident's consent) to the State Agency within 24 hours of an allegation for 1 (R #17) of 4 (R #16, R #17, R #27, and R #29) residents reviewed for misappropriation of property, when staff failed to report allegations of missing money for R #17. If the facility fails to report allegations of misappropriation of resident property to the state agency within 24 hours of the allegation, then corrective action may not be taken, and residents may suffer increased anxiety and fear that their belongings are not being protected. The findings are:A. Record review of R #17's admission Record, no date, revealed the following: 1. R #17 was admitted to the facility on [DATE]. 2. R #17 had a diagnosis of cognitive communication deficit (difficulty with verbal or non-verbal communication caused by underlying cognitive deficits, rather than primary speech or language impairments). B. Record review of the Grievance Log, dated March 2026, revealed that on 03/03/26 R #17 reported she was missing money. C. Record review of R #17's grievance form, dated 03/03/26, revealed the following: 1. R #17 reported that she was missing $44. 2. On 03/05/26, staff documented that R #17 stated that she was not missing any money. D. On 03/11/26 at 1:18 PM, during an interview, R #17 stated the following: 1. She was missing $44 from her purse.2. The money went missing about a week or two (2) before 03/11/26. 3. She told a staff member in the business office that she was missing money (she was unsure of staff name or title or the date she notified staff). E. Record review of the State Agency Incident Management System, no date, revealed staff did not report R #17's missing money to the State Agency. F. On 03/12/26 at 10:54 AM, during an interview, the Administrator stated the following: 1. She confirmed that she did not report R #17's grievance about missing $44 to the State Agency, because R #17 did not state that she thought someone stole her money. 2. The Administrator only reports missing money or property to the State Agency if the resident alleges theft or if the resident reports that they saw someone going through their belongings.

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to thoroughly investigate an allegation of misappropriation of property (the deliberate misplacement, exploitation, or wrongful, temporary, or permanent use of a resident's belongings or money without the resident's consent) for 1 (R #17) of 4 (R #16, R #17, R #27, and R #29) residents reviewed for misappropriation of property. If the facility does not adequately investigate allegations of misappropriation of resident property, then corrective action may not be implemented to protect other residents which could cause residents to suffer increased anxiety and fear that their belongings are not being protected. The findings are:A. Record review of R #17's admission Record, no date, revealed the following: 1. R #17 was admitted to the facility on [DATE]. 2. R #17 had a diagnosis of cognitive communication deficit (difficulty with verbal or non-verbal communication caused by underlying cognitive deficits, rather than primary speech or language impairments). B. Record review of the Grievance Log, dated March 2026, revealed that R #17 reported that she was missing money. C. Record review of R #17's grievance form, dated 03/03/26, revealed the following: 1. R #17 reported that she was missing $44. 2. On 03/05/26, staff documented that R #17 stated that she was not missing any money. D. On 03/11/26 at 1:18 PM, during an interview, R #17 stated the following: 1. She was missing $44. 2. Her money went missing about a week or two (2) before 03/11/26. 3. She told a staff member in the business office that she was missing money (she was unsure of staff name or title or the date she notified staff). 4. Her money was in a pink bag in her purse when it went missing. 5. She was planning to buy pants with the money. 6. She could not remember if staff talked to her after she reported that her money was missing. 7. She forgets things frequently. E. On 03/11/26 at 1:25 PM, during an interview, the Social Services Clerk (SSC) stated the following: 1. The Business Office Manager (BOM) told her that R #17 was missing money on 03/03/26. 2. She completed the grievance form for R #17 on 03/03/26. 3. She helped R #17 look through her drawers for the missing money on 03/03/26. 4. On 03/05/26 she met with R #17 again and R #17 told her the following: a. She was not missing any money. b. She might have given the money to her kids. 6. She did not call R #17's kids to ask if R #17 had given them money. 7. She did not report R #17's missing money to the police. F. On 03/11/26 at 1:40 PM, during an interview, the BOM stated the following:1. R #17 had withdrawn $100 on 02/27/26.2. When R #17 withdrew the $100 on 02/27/26, she told the BOM that she planned to have her daughter buy clothes for her.3. During a morning meeting on 03/03/26, a staff member reported that R #17 was missing money.4. R #17 frequently buys snacks from the facility vending machines.5. She was unsure if anyone contacted R #17's kids to ask if R #17 gave them any money.6. R #17's Daughter was her Power of Attorney (POA, is a legal document enabling a trusted person (agent/attorney-in-fact) to act on your behalf regarding financial, legal, or medical matters). G. On 03/12/26 at 9:37 AM, during an interview, R #17's Daughter stated the following: 1. R #17 called her on 03/01/26 and told her that she was missing $44 from her purse. 2. R #17 did not give her any money. 3. Sometimes R #17 would give the activities staff money to buy things for R #17. 4. R #17 gets very confused and sometimes forgets. 5. Facility staff did not notify her that R #17 reported missing money or ask if R #17 gave her money. H. Record review of the Administrator's investigation note, dated 03/03/26, revealed the following:1. She spoke with R #17 regarding missing $44. 2. R #17 told the Administrator that she wasn't missing any money. 3. R #17 told the Administrator that she gives her money to her kids. 4. R #17 did not state that her money was stollen. 5. The BOM confirmed that R #17 withdrew $100 from her account on 02/27/26. 6. R #17 told the administrator that she buys things from the vending machines. I. Record review of the SSC's investigation notes revealed the following: 1. Note dated 03/03/26: a. R #17 told the SSC that she was not missing any money. b. R #17 gave SSC permission to look through her drawers for her missing money. c. R #17 told the SSC that she may have given the money to her kids for clothes. 2. On 03/05/26, R #17 told the SSC that she was not missing any money. J. On 03/12/26 (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	at 12:58 PM, during an interview, the Administrator confirmed the following: 1. On 03/03/26 during a morning meeting, a nurse (did not specify which nurse) reported that R #17 was missing $44. 2. She did not know which staff member R #17 reported that she was missing money. 3. She was not sure how long R #17's money had been missing.4. She did not interview nursing staff or CNA's to see if they witnessed anything regarding R #17's missing money. 5. She did not review cameras to see if anyone took R #17's money. 6. She did not call R #17's kids to see if R #17 gave them money. 7. She did not interview the activities staff to see if R #17 gave them money to buy her something. 8. After R #17 told her and the SSC that she was not missing any money on 03/03/26, she did not investigate further.

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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. Based on record review and interview, the facility failed to ensure care plans were revised for 1 (R #24) of 5 (R #24, R #25, R #26, R #27 and R #28) residents when staff failed to revise R #24's care plan with the most current resident information regarding care preferences. 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 #24's admission Record, no date revealed the following: 1. An admission date of 12/24/19. 2. R #24 diagnoses of unspecified dementia, unspecified severity, with other behavioral disturbances (a type or severity of dementia that is not clearly determined, and the patient exhibits behavioral disturbances such as agitation, aggression, psychosis, mood changes, and sleep disturbances). B. Record review of R #24's 5-day complaint narrative note (the facility's incident follow up report to the State Agency) dated 12/17/25 revealed the following: 1. R #24 reported to staff that a male staff member attempted to kiss her forehead. 2. Facility corrective action was to implement that only female staff provide care to R #24. C. Record review of R #24's care plan revision dated 03/03/26 revealed staff did not revise the care plan to include only females to provide care for R #24. D. On 03/12/26 at 12:32 PM, during an interview, the DON confirmed R #24's care plan was not revised with the intervention that only female staff will provide care for R #24. DON stated that R #24's care plan should have been revised with this intervention.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure medical records were complete and accurate for 1 (R #18) of 3 (R #17, R #18, and R #27) residents reviewed accuracy of documentation when staff failed to: 1. Document R #18's enteral feedings (tube feeding, delivers liquid nutrition directly into the stomach or small intestine via a tube for individuals unable to meet nutritional needs orally, despite having a functional gastrointestinal tract.) 2. Document R #18's residual volume (the amount of formula and gastric juice remaining in the stomach, often checked to assess tube feeding tolerance).3. Document R #18's enteral flushes (water administered through enteral tube). These deficient practices have the potential to negatively impact the care staff provide to meet residents' needs due to inaccurate records. The findings are:A. Record review of R #18's admission Record, no date, revealed the following:1. R #18 was admitted to the facility on [DATE].2. R #18 had the following diagnoses: a. Dysphagia oropharyngeal phase (difficulty initiating a swallow, moving food from the mouth to the throat, and into the esophagus). b. Gastrostomy (indicates the presence of a functioning feeding tube (G-tube) inserted through the abdomen into the stomach for long-term nutritional support or gastric decompression). B. Record review of R #18's physician's orders revealed the following: 1. An order dated 12/02/25 and discontinued on 12/31/25, for enteral feeding with Jevity 1.5 (a balanced liquid nutrition for long- or short-term tube feeding), one (1) carton every four (4) hours. 2. An order dated 01/03/26 and discontinued on 01/06/26, for enteral feeding with Jevity 1.2 at a rate of 70 milliliters (mL, unit for measuring liquids) per hour, and 150 mL of water every six (6) hours. 3. An order dated 01/03/26 and discontinued on 03/04/26, to flush enteral tube with 30 mL's water before and after medication administration and 5-10 mL's water between each medication. 4. An order dated 01/03/26 and discontinued on 02/26/26, to check residual before med administration. If residual volume is greater than 60 mL, hold feeding and notify physician. 5. An order dated 11/24/26 and discontinued on 03/04/26, revealed an order for phenobarbital (medication used to treat seizures) 64.8 mg, give two (2) tablets via PEG-Tube once a day for seizures. 6. An order dated 01/03/26 and discontinued on 02/06/26, for docusate sodium (an over-the-counter stool softener used to treat occasional constipation) 100 mg, give one tablet via PEG-Tube two times a day for constipation. C. Record review of R #18's MAR, dated December 2025, revealed staff did not document administering R #18's bolus feedings on following dates and times:1. On 12/02/25 at 8:00 PM.2. Between 12/03/25 to 12/09/25 at 12:00 AM, 4:00 AM, 8:00 AM, 12:00 PM, 4:00 PM, or 8:00 PM.3. On 12/10/25 at 12:00 AM, 4:00 AM, 4:00 PM, or 8:00 PM.4. On 12/11/25 at 12:00 AM, 4:00 AM, 4:00 PM, or 8:00 PM.5. On 12/12/25 at 12:00 AM, 4:00 AM, 4:00 PM, or 8:00 PM.6. On 12/13/25 at 12:00 AM, 4:00 AM, 8:00 AM, 12:00 PM, 4:00 PM, or 8:00 PM.7. On 12/14/25 at 12:00 AM, 4:00 AM, 4:00 PM, or 8:00 PM.8. On 12/15/25 at 12:00 AM, 4:00 AM.9. On 12/24/25 at 8:00 PM. D. Record review of R #18's MAR, dated January 2026, revealed the following:1. On 01/04/26 for the 6AM-6PM shift, staff did not document administration of R #18's Jevity at 70 mL per hour and 150 mL of water every six (6) hours.2. On 01/04/26 staff documented administering R #18's 9:00 AM dose of Phenobarbital and Docusate Sodium.3. On 01/04/26 for the 6AM-6PM shift, staff did not document flushing R #30's enteral tube with 30 mL of water before and after medication administration and 5-10 mL of water between each medication.4. On 01/04/26 for the 6AM-6PM shift, staff did not document that R #18's residual volume was checked before medication administration and staff did not document the amount of residual volume R #18 had.5. On 01/05/26 for the 6AM-6PM shift, staff did not document administration of R #18's Jevity at 70 mL per hour and 150 mL of water every six (6) hours.6. On 01/05/26 staff documented administering R #18's 9:00 AM dose of Phenobarbital and Docusate Sodium.7. On 01/05/26 for the 6AM-6PM shift, staff did not document flushing R #30's enteral tube with 30 mL of water before and after medication administration and 5-10 mL of water between each (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	medication.8. On 01/05/26 for the 6AM-6PM shift, staff did not document that R #18's residual volume was checked before medication administration and staff did not document R #18's residual volume. E. On 03/10/26 at 12:03 PM, during an interview, LPN #16 stated the following: 1. R #18 was able to tell staff when he was hungry and make his needs known. 2. She administered R #18's feedings as ordered. F. On 3/12/26 at 9:25 AM, during an interview, LPN #24 stated the following: 1. He administered R #18's enteral feedings as ordered. 2. He followed all physicians' orders. 3. He checked R #18's residual volume as ordered and would notify the provider if R #18 had too much residual volume. G. On 03/13/26 at 12:18 PM, during an interview, the DON confirmed the following: 1. Staff did not document multiple bolus feedings for R #18's between 12/02/26 and 12/24/25. 2. Staff did not document administering R #18's continuous feedings on the mornings of 01/04/26 or 01/05/26. 3. Staff did not document checking R #18's residual volume on the mornings of 01/04/26 or 01/05/26. 4. Staff did not document administering water flushes to R #18 on the mornings of 01/04/26 or 01/05/26. 5. Staff were expected to follow all orders and document in the medical record.