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	06/05/2025

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on observation and interview, the facility failed to ensure residents were treated with respect and dignity for 2 (R #86 and R #253) of 3 (R #33, R #86 and R #253) residents when the facility failed to do the following: 1. Use a privacy bag for R #86's foley catheter bag (a urine drainage bag that collects urine from the bladder). 2. Treat R #253 with dignity when serving him lunch. The findings are: R #86 A. On 06/02/25 at 3:15 PM, during an observation of the 600 unit, R #86's catheter bag did not have a privacy bag (a discreet cover that conceals the urine drainage bag from view). B. On 06/02/25 at 3:18, during an interview, CNA #8 confirmed that there was not a privacy bag on R #86's catheter bag. C. On 06/02/25 at 3:42, during an interview, the DON said that catheters bags should have a privacy cover. R #253 D. Record review of R #253's administration record, no date revealed the following: 1. R #253 was admitted to the facility of 05/12/17. 2. R #253 diagnoses included the following: a. Muscle weakness (generalized). b. Hemiplegia, unspecified affecting the left non dominant side. (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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	c. Contracture of muscle (a type of scarring in your soft tissues that causes them to tighten and stiffen), unspecified upper arm. E. On 06/1/25 at 12:35 PM, during an observation of R #253's room revealed the following: 1. The medical records coordinator passed out the meal tray to R #253 for lunch. 2. The medical records coordinator entered R #253's room with a meal tray and stated, I have your lunch. 3. R #253 asked to keep his food on the meal tray, and the medical record coordinator stated, I'm not supposed to leave your food on the meal tray. R #253 insisted on keeping his meal tray. The medical records coordinator dropped the meal tray on R #253's bedside table. The medical records coordinator rushed out of R #253's room without further communication with R #253 and sighed heavily. 4. The medical records coordinator did not offer to set up R #253's lunch tray, and did not assist R #253 to open any containers or place the bedside table within R #253's reach. 5. R # 253 looked at this surveyor with a puzzled look on his face and stated, You saw that right? R #253 then attempted to reach for the bedside table but was unable to move it within his reach. F. On 06/01/25 at 12:40 PM, during an interview with LPN #28, she stated that she would get a CNA to assist R #253 immediately with his meal setup. LPN #28 stated that the medical records coordinator should not have treated R #253 in that manner. G. On 06/01/25 at 1:30 PM, during an interview with the medical records coordinator, stated the following: 1. The facility was short staffed, and she assisted with passing meal trays. 2. When she passes out meal trays she knocks on door and puts tray in front of the resident removing tray and overhead warmer containers. 3. If a resident prefers to keep food on meal tray the resident can keep it. 4. She has taken resident rights training. H. On 06/05/25 at 9:27 AM, during an interview with R #253, he stated he figured the medical records coordinator was a new employee, and probably shouldn't have been serving people their food, and said he felt indifferent about what happened. I. On 06/05/25 at 1:57 PM, during an interview with the administrator, she confirmed that she expects her staff to treat residents with dignity and respect, and her expectations would be that staff treat all residents with dignity and respect.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Recite from 04/24/24 Based on observation, record review, and interview, the facility failed to notify the provider of missed medication doses and treatment for 2 (R #46 and R #86) of 2 (R #46 and R #86) residents reviewed for medication administration and edema, (swelling caused by an accumulation of fluid in the body's tissues, often in the feet, ankles, and legs). when staff failed to: 1. Notify the provider that R #46 refused her lactulose (medication used to treat constipation. It can also treat liver disease) on 06/04/25. 2. Notify the provider that R #46 received a partial (incomplete) dose of Albuterol (medication that is inhaled to treat or prevent spasms of the respiratory tract) on 06/04/25. 3. Notify the provider that R #86 does not wear her compression stockings (specialized hosiery designed to help prevent the occurrence of, and guard against further progression of, venous disorders such as edema, phlebitis and thrombosis) as ordered. These deficient practices could likely result in residents not receiving the necessary care or worsening medical conditions due to lack of treatment. The findings are: R #46 A. Record review of R #46's physician's orders, multiple dates, revealed the following: 1. Order dated 02/17/25, for Lactulose 20 Grams (GM, unit of measure) per 30 milliliters (ML, unit of measure), give 30 ML once a day for constipation (problem with passing stool). 2. Order dated 03/23/25, for ProAir HFA Inhalation Aerosol Solution (Albuterol Sulfate), inhale two puffs orally four times a day for pulmonary embolism (a blood clot gets stuck in an artery in the lung, blocking blood flow to part of the lung) without acute cor pulmonale (blockage of an artery of the lung) and chronic obstructive pulmonary disease (COPD, a condition caused by damage to airways or other parts of the lung). B. On 06/04/25 at 9:13 AM, during an observation of medication administration, revealed the following: 1. R #46 refused to take Lactulose. 2. R #46 took one puff of Albuterol Inhalation solution. C. On 06/04/25 at 9:13 AM, during an interview, LPN #16, stated the following: 1. She confirmed that R #46's Albuterol order was for two puffs. 2. She confirmed that R #46 only took one puff of Albuterol. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3. She confirmed that R #46 refused to take Lactulose. D. Record review of R #46's MAR, dated June 2025, revealed the following: 1. Staff documented that R #46 refused lactulose. 2. Staff documented that R #46 took Albuterol. E. Record review of R #46's progress notes, dated 06/04/25, revealed the following: 1. Staff documented that R #46 had one puff of Albuterol. 2. Staff did not document that the provider was notified about R #46 refusing Lactulose. 3. Staff did not document that the provider was notified about R #46 only taking one puff of Albuterol. F. On 06/05/25 at 4:31 PM, during an interview, RN #16 stated the following: 1. When a resident refuses a medication or takes only a partial dose of a medication, staff are expected to document that the resident refused or received a partial dose. 2. Staff are expected to notify the provider. 3. Staff are expected to document the communication with the provider in the medical record. 4. She confirmed that staff documented that R #46 refused Lactulose on 06/04/25 and that she received one puff of Albuterol on 06/04/25. 5. She confirmed that the medical record did not have documentation that the provider was notified that R #46 refused Lactulose or that she received a partial dose of Albuterol. G. On 06/05/25 at 5:03 PM, during an interview, the DON confirmed the following: 1. Staff are expected to notify the provider if a resident refuses medication or if they receive a partial dose of medication. 2. Staff are expected to document all contact with the provider in the medical record. R #86 H. Record review of R #86's admission record (no date) revealed the following: 1. R #86 was admitted to the facility on [DATE]. 2. R #86 has a diagnosis of edema. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	I. Record review of R #86's physician's order dated 01/26/25 revealed for staff to put on compression stockings in the morning before getting dressed for pitting edema. J. Record review of R #86's May 2025 TAR (treatment administration record) revealed no documentation of R #86's compression stockings being put on the resident. K. On 06/02/25 at 2:55 PM, during an interview, R #86 said she did not have compression stockings on. R #86 said that staff have only put the stockings on her a couple of times since she has been at the facility. L. On 06/02/25 at 3:16 PM, during an interview, CNA #18 said that R #86 refuses to wear compression stockings. M. On 06/02/25 at 3:19 PM, during an interview, RN #8 confirmed that R #86 is not wearing compression stockings. RN #8 said that R #86 would not keep the compression stockings on. RN #8 said that he has not notified the physician that the resident is not compliant with the order for compression stockings. RN #8 said that he does not see documentation that R #86 is refusing to wear compression stockings or that the provider has been notified. N. On 06/02/25 at 3:36 PM, during an interview, the DON said that if R #86 is not compliant with an order that the physician should be notified.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Recite from [DATE] Based on observation and interview, the facility failed to provide a comfortable and homelike environment for all 69 residents who do not reside in the secure unit (residents were identified by the census provided by the Administrator on [DATE]) when staff failed to: 1. Store a deceased resident's belongings out of common areas share by residents. 2. Repair the floor in front of R #31's restroom, and replace ceiling covers above R #31's bed. These deficient practices could likely cause residents to feel like they are not living in a comfortable home like environment and like they are not valued. The findings are: A. On [DATE] at 2:28 PM an observation of R #31's room revealed the floor in front of R #31's restroom door had a deep indention in the floor, and the ceiling above R #31's bed had 2 large brown stains. B. On [DATE] at 2:28 PM during an interview with the Maintenance director, he confirmed the floor in front of R #31's restroom door had a deep indention in the floor, and the ceiling above R #31's bed had two large brown stains. The Maintenance director stated he was not aware of this and there were no work orders regarding these issues, and he would get this fixed right away. C. On [DATE] at 1:35 PM during a phone interview with the state ombudsman, she stated that she had visited the facility the week of [DATE] through [DATE] and noticed there were several large black trash bags in the main hall of the facility. She stated that you can see it upon entering the building and the trash bags make the facility entrance look cluttered. D. On [DATE] at 9:40 AM during an observation of the main hall, ten large black trash bags, in an open area of the main hall of the facility. E. On [DATE] at 9:05 AM during an interview, the Administrator said that the bags contained the belongings of a resident that passed away and are waiting for family to pick them up. The Administrator said that they keep them there so that when family comes, they have access to them (the Administrator did not indicate how long they had been there).

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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 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure residents did not receive psychotropic medications (group of drugs that affect behavior, mood, thoughts, or perception) unless the medication was medically necessary for 4 (R #14, R #15, R #33 and R #63) of 7 (R #14, R #15, R #18, R #28, R #33, R #35 and R #63) residents reviewed for unnecessary medications, when staff failed to ensure: 1. A gradual dose reduction (GDR; stepwise tapering of a dose to determine if symptoms, conditions, or risks can be managed by a lower dose or if the dose or medication can be discontinued) was carried out for R #14 and R #63. 2. Psychotropic medications ordered to be given as needed (PRN) for R #15 and R #33 were not prescribed for longer than 14 days without documentation of the rationale to extend beyond 14 days in the resident's medical record including an indication for the duration of the PRN order. These deficient practices could likely result in residents receiving medications without a medical reason and being at a higher risk of adverse side effects (unwanted, harmful, or abnormal result). The findings are: Gradual Dose Reduction R #14 A. Record review of R #14's admission record (no date) revealed the following: 1. R #14 was admitted to the facility on [DATE]. 2. R #14 has a diagnosis of other recurrent depressive disorders (mental health condition with symptoms characteristic of a depressive disorder such as persistent sadness that cause clinically significant distress but do not meet the full criteria for any other depressive disorder). B. Record review of R #14's physician's orders revealed an order dated 09/25/24 for Prozac (antidepressant medication primarily used to treat depression disorders) capsule 20 mg, give 1 capsule by mouth one time a day for depression. Start date: 09/16/24. C. Record review of R #14's Medication Administration Record (MAR; electronic form used by nursing staff to document when medication is given), dated 05/01/25 through 05/31/25, revealed R #14 received Prozac (fluoxetine) 20 mg every morning from 05/01/25 through 05/31/25. D. Record review of R #14's Medication Regimen Review (form provided to the facility with pharmacist recommendation) dated 03/14/25, revealed the following: 1. Gradual dose reduction request: Medication fluoxetine 20 mg once daily. (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. Residents who use psychotropic drugs must have GDR attempts unless clinically contraindicated, in an effort to discontinue these drugs. Do you feel a reduction could be attempted on the above medication at this time? 3. The form was electronically signed by the pharmacist. 4. The physician response section was blank, and the form was not signed by a physician. E. On 06/05/25 at 4:10 PM during a joint interview, the DON and the Regional Nurse Consultant (RNC) confirmed the following: 1. R #14 has not had a GDR for fluoxetine. 2. The medical director did not provide a rationale in R #14's medical record indicating the reason a GDR was not completed for R #14 as recommended by the pharmacist. R #63 F. Record review of R #63's admission record (no date) revealed the following: 1. R #63 was admitted to the facility on [DATE]. 2. R #63 diagnosis as follows: a. Unspecified dementia, moderate, with psychotic disturbance (diagnosis that encompasses a range of symptoms that lead to a decline in skills your brain uses to complete daily tasks, can cause abnormal thinking and perceptions but specific details regarding the condition are not clearly defined). b. Other recurrent depressive disorders. c. Unspecified dementia, unspecified severity, with other behavioral disturbances (confusion or mild cognitive impairment that cannot be clearly diagnosed and include consistent patterns of actions or responses that disrupt daily life . G. Record review of R #63's physician's orders, multiple dates, revealed the following: 1. Order dated 06/14/23 for divalproex sodium oral tablet delayed release (antiseizure medication commonly used to treat seizures, bipolar disorder and to prevent migraine headaches) 250 mg, give 1 tablet by mouth three times a day for behavioral disturbances in dementia. 2. Order dated 08/14/23 for buspirone (anti-anxiety commonly used to treat symptoms of anxiety, such as fear, tension, irritability, dizziness, pounding heartbeat, and other physical symptoms) oral tablet, give 7.5 mg by mouth two times a day for sexually inappropriate behaviors (behaviors such as sexual conversation, inappropriate touching or grabbing that occur when a person has lost the ability to inhibit behavior) ordered by [name of psychiatric service provider]. (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. Order dated 07/24/24 for sertraline tablet give 100 mg by mouth one time a day for depression. H. Record review of the Psychotropic Medication Utilization Report (pharmacist spreadsheet that includes information about the use of psychotropic, sedative, and hypnotic medications) dated 03/14/25 revealed the following: 1. R #63 had an order for divalproex three times a day since 06/14/23, and a GDR was declined in September 2024. 2. R #63 had an order for buspirone 7.5 mg two times a day since 08/14/23, and a GDR was declined in July 2024. 3. R #63 had an order for sertraline 100 mg one time a day since 07/24/24, and a GDR was declined in November 2024. I. Record review of R #63's MAR, dated 05/01/25 through 05/31/25, revealed the following: -divalproex 1. R #63 received divalproex 250 mg three times daily from 05/01/25 through 05/09/25 2. R #63 received divalproex 250 mg at 8 AM on 05/10/25. 3. R #63 received divalproex 250 mg at 7 PM on 05/10/25. 4. R #63 received divalproex 250 mg three times daily from 05/11/25 through 05/31/25 -buspirone 5. R #63 received buspirone 7.5 mg two times a day from 05/01/25 through 05/31/25 -sertraline 6. R #63 received sertraline 100 mg one time a day from 05/01/25 through 05/31/25. J. On 06/05/25 at 4:20 PM, during a joint interview, the DON and the Regional Nurse Consultant (RNC) confirmed the following: 1. R #63 has not had a GDR for divalproex, buspirone or sertraline. 2. R #63's physician did not provide a rationale in R #63's medical record, indicating the reason a GDR was not completed for R #63 as recommended by the pharmacist. PRN psychotropic medications R #15 K. Record review of R #15's admission record, no date revealed the following: (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1. R #15 was admitted to the facility on [DATE]. 2. R #15 has diagnosis of anxiety. L. Record review of R #15's physician's orders dated 04/08/25 for Lorazepam (medication that can be used to treat anxiety) 0.5 mg 1 tab via PEG-Tube every 4 hours as needed for anxiety. M. Record review of R #15's MAR, dated 05/01/25 through 05/31/25, revealed on 05/09/25, R #15 received Lorazepam 0.5 mg PRN (as needed). N. Record review of the medication regimen review form, dated 04/09/25 revealed the following: 1. The recommendation to consider discontinuing the Lorazepam medication if R #15 still benefits from PRN use, R # 15 requires PRN psychotropic medication due to Hospice care. 2. Lorazepam medication anticipation of duration of use for R #15 was left blank. Physician marked agree with this recommendation. 3. Medical director signed the medication regimen review for on 04/20/25. O. On 06/05/25 at 2:22 PM, during an interview with DON, she stated Lorazepam PRN medication for R #15 should have an end date. DON confirmed that PRN medications should have an end date, and she will work on getting that done. R #33 P. Record review of R #33's admission record, no date revealed the following: 1. R #33 was admitted to the facility on [DATE]. 2. R #33 has diagnosis of seizures. Q. Record review of R #33's physician's orders dated 05/27/25 for Ativan (Lorazepam) injection solution 2 mg/ml every 4 hours as needed for seizures. R. Record review of R #33's medical record, no date, revealed the record did not have any documented rationale in the resident's medical record and the duration for the PRN order was not indicated. S. On 06/05/25 at 3:51 PM, during an interview, the DON said that there should be a rationale and end date for PRN Ativan for R #33.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Recite from 04/24/24 Based on interview and record review, the facility failed to ensure the Minimum Data Set Assessment (MDS; federally mandated assessment instrument completed by facility staff) were accurate for 2 (R #35 and R #66) of 9 (R #14, R #21, R #28, R #35, R #46, R #60, R #63, R #66 and R #77) residents reviewed for accurate MDS assessments. This deficient practice could likely result in the facility not having an accurate assessment of the residents' needs. The findings are: R #35 A. Record review of R #35's admission documents, no date, revealed R #35 was admitted to the facility on [DATE]. B. Record review of R #35's history and physical (H&P, physician obtains a thorough medical history from the patient, performs a physical examination, and then documents their findings), dated 04/25/25 revealed the following: 1. R #35 had a diagnosis of chronic systolic heart failure with an onset (start) date of 11/27/24. 2. R #35 had a diagnosis of chronic diastolic heart failure with an onset date of 11/02/24. C. Record review of R #35's care plan dated 11/12/24 revealed R #35 had a diagnosis of congestive heart failure. D. Record review of R #35's quarterly MDS assessment, dated 05/09/25, revealed staff did not document that R #35 had a diagnosis of heart failure. E. On 06/05/25 at 4:58 PM, during an interview, the DON and the administrator stated the following: 1. R #35 had the following diagnoses according to R #35's H & P dated 04/25/25: a. Chronic diastolic heart failure b. Chronic systolic heart failure. 2. R #35's quarterly MDS, dated [DATE], did not include that R #35 had a diagnosis of heart failure. 3. Staff should have documented R #35's diagnosis of heart failure in her MDS. R #66 F. On 06/01/25 at 1:05 PM, during an interview, R #66 stated his gums sometimes hurt when he eats because he has no teeth. G. Record review of R #66's dental visit note dated 05/02/25 revealed the following: (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1. Chief complaint: I want dentures, I lost my old ones, 2. Diagnosis: complete maxillary and mandibular edentulism (absence of teeth in both the upper and lower jaw). H. Record review of R #66's care plan initiated 09/14/23 revealed R #66 is at risk for an oral/dental health problem related to no natural teeth. I. Record review of R #66's Annual MDS dated [DATE] revealed the following: 1. Section L- Oral/Dental status L0200 Dental: a. Staff did not document: No natural teeth or tooth fragment(s). J. On 06/05/25 at 4:10 PM during a joint interview, the administrator and the Regional Nurse Consultant (RNC) confirmed the following: 1. R #66 is edentulous. 2. R #66's annual MDS was not accurate.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Recite from 10/18/24 Based on record review and interview, the facility failed to create an accurate baseline care plan (minimum healthcare information necessary to properly care for a resident immediately upon their admission to the facility) within 48 hours of admission for 1 (R #254) of 3 (R #33, R #72 and R#254) residents reviewed for baseline care plans. This deficient practice could likely result in residents not receiving the appropriate care and may place residents at risk of an adverse event (undesirable experience, preventable or non-preventable, that caused harm to a resident because of medical care or lack of medical care) or worsening of current condition after admission. The findings are: A. Record review of R #254's admission Record, no date, revealed R #254 was admitted into the facility on [DATE]. B. On 06/01/25 at 12:08 PM during an interview, R #254 said he has had a catheter for a while, no date given. C. Record review of R #254's order dated 05/30/25 revealed foley catheter (a thin, flexible tube used to drain urine from the bladder when a person is unable to urinate normally) for medical necessity. D. Record review of R #254's care plan dated 05/30/25 revealed the care plan did not contain any documentation of a foley catheter, interventions and care. E. On 06/05/25 at 3:47 PM during an interview, the Administrator said that R #254's foley catheter should be care planned so that R #254 is provided proper care.

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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** Recite from 08/21/24 Based on observation, record review, and interview, the facility failed to develop and implement accurate, person-centered comprehensive care plan for 2 (R #21 and R #33) of 4 (R #21, R #28, R #33, and R #35) residents reviewed for care plans when staff failed to: 1. Ensure R #21 had a fall mat in place next to her bed as indicated in her care plan. 2. Include R #33's diagnosis of dementia and interventions in place to treat R #33's dementia. These deficient practices could likely result in resident injury and staff being unaware of the current and actual needs of the residents. The findings are: R #21 A. Record review of R #21's admission documents, no date, revealed the following: 1. R #21 was admitted to the facility on [DATE]. 2. R #21 had the following diagnoses: a. History of falling. b. Muscle weakness. c. Cognitive communication deficit (a person has difficulty communicating because of injury to the brain that controls the ability to think). d. Personal history of traumatic brain injury (Brain dysfunction caused by an outside force, usually a violent blow to the head). e. Metabolic encephalopathy (a change in how your brain works due to an underlying condition). B. Record review of R #21's care plan dated 09/23/24 revealed the following: 1. R #21 had actual falls with injury. 2. A fall mat in place next to R #21's bed. C. On 06/04/25 at 1:00 PM, during an observation of R #21 in her room, R #21 laid in her bed and a fall mat was not next to her bed. D. On 06/05/25 at 2:21 PM, during an observation of R #21 in her room, R #21 laid in her bed and a fall mat was not next to her bed. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	E. On 06/05/25 at 2:22 PM, during an interview, CNA #16 confirmed R #21 did not have a fall mat next to her bed. F. On 06/05/25 at 2:24 PM, during an interview, LPN #18 stated the following: 1. She did not think R #21 was supposed to have a fall mat. 2. She confirmed R #21's care plan intervention for falls included that R #21 was to have a fall mat when she was in bed. G. On 06/05/25 at 2:29 PM, during an interview, the DON confirmed the following: 1. R #21 should have had a fall mat next to her bed if it was in her care plan. 2. Staff are expected to ensure residents have a fall mat next to their bed if their care plan indicates that a fall mat is needed. R #33 H. Record review of R #3's admission documents, no date, revealed the following: 1. R #33 was admitted to the facility on [DATE]. 2. R #33 had a diagnosis of dementia without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety. I. Record review of R #33's care plan dated 05/30/25 revealed that R #33's dementia and interventions for maintaining his highest practicable wellbeing were not documented in his care plan. J. On 06/04/25 at 3:06 PM during an interview, the DON confirmed that R #33's dementia diagnosis and interventions are not care planned. The DON said that R #33's diagnosis should be documented to provide R #33 with care that is needed to help with his memory and to maintain his health.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** Recite from 08/21/24 Based on record review and interview, the facility failed to ensure care plan revisions occurred for 2 (R #68 and R #86) of 6 (R #21, R #28, R #33, R #35, R #68, and R #86) residents when the staff failed to revise the care plan with the most current resident information. 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: R #68 A. Record review of R #68's admission documents, no date, revealed he was admitted to the facility on [DATE]. B. Record review of R #68's physician's orders, multiple dates, revealed the following: 1. An order dated 05/27/25, to monitor right heel daily for redness. 2. An order dated 05/20/25 and discontinued on 05/27/25 for wound care to the right heel. 3. An order dated 03/19/25 and discontinued on 04/05/25 for strict isolation. Droplet/Contact precautions (intended to prevent transmission of infectious agents, including epidemiologically important microorganisms, which are spread by direct or indirect contact with the patient or the patient's environment). 4. An order dated 05/04/25 and completed on 05/17/25 for Ertapenem Sodium Solution (antibiotic used to treat certain serious infections) 1 gram to be administered intravenously (through a vein) once a day for two weeks due to wound infection. C. Record review of R #68's care plan, revised 05/11/25, revealed the following: 1. R #68 was on antibiotic therapy for wound infection. 2. R #68 was on strict contact isolation. D. On 06/04/25 at 11:07 AM, during an interview, the wound care nurse confirmed the following: 1. R #68's wound was healed. 2. R #68 was no longer receiving antibiotic therapy for his wound infection. 3. R #68 was no longer on contact isolation precautions. E. On 06/05/25 at 4:51 PM, during an interview, the DON confirmed the following: (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1. R #68's care plan included that he was on antibiotic therapy for a wound. 2. R #68's care plan included that he was on strict contact isolation. 3. R #68's care plan should have been revised when his antibiotic therapy was completed. 4. R #68's care plan should have been revised when he was removed from contact isolation. R#86 F. Record review of R #86'S admission documents, no date, revealed R #86 was admitted to the facility on [DATE]. G. Record review of R #86's physician's orders, multiple dates, revealed the following: 1. An order dated 01/26/25, staff to put on compression stocking in the morning for pitting edema (occurs when excess fluid builds up in the body, causing swelling; when pressure is applied to the swollen area, a pit, or indentation, will remain). 2. An order dated 01/26/25, staff to remove compression stocking at bedtime. H. Record review of R 86's care plan dated 12/20/25 revealed that R #86's compression stockings and interventions were not documented. I. On 06/02/25 at 3:36 PM during an interview, the DON said that R #86's compression stockings and interventions should be care planned for to ensure that R #86 receives care as ordered by the provider.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. Recite from 10/18/24 Based on observation, interview, and record review, the facility failed to ensure residents received care that meets professional standards for 1 (R #86) of 1 (R #86) resident sampled for limited range of motion, when staff failed to follow the order for compression stockings (specially designed hosiery that provide controlled compression to the legs, promoting blood flow and reducing swelling). This deficient practice could likely result in worsening of resident's edema (excess of watery fluid collecting in the cavities or tissues of the body) or unnecessary pain and discomfort. The findings are: A. On 06/02/25 at 2:55 PM during an interview and observation, R #86 said that she did not have compression stockings on. R #86 said that staff had only put the stockings on a couple of times since she has been in the facility. R #86's legs were swollen and puffy. B. Record review of R #86's orders revealed an order dated 01/26/25 for compression stockings to be put on in the morning before getting dressed for pitting edema for 30 administrations and every 24 hours as needed for pitting edema. C. Record review of R #86's TAR (treatment administration record) for May 2025 revealed staff did not document putting compression stockings on R #86 for the entire month. D. On 06/02/25 at 3:19 PM during an interview, LPN #8 confirmed that there was no documentation that R #86 is wearing compression stockings as ordered. LPN #8 confirmed that R #86 had edema and that she did not have compression stockings on. E. On 06/02/25 at 3:36 PM during an interview, the DON said that R #86's orders should be followed and if R #86 is not compliant with the orders, the physician should be notified.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observation, and interview, the facility failed to provide activities of daily living (ADL) assistance for 2 (R #2 and R #33) of 2 (R #2 and R #23) residents reviewed for ADL care when staff failed to do the following: 1. Assist R #2 with toenail care. 2. Assist R #33 with nail care. This deficient practice is likely to affect the dignity and health 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 is diagnosed with Type 2 Diabetes Mellitus with Diabetic Polyneuropathy. B. On 06/03/25 at 9:24 AM, during an interview with R #2 and observation of R #2's foot, she stated that her toenails are long and her great toe on right foot is curving and it hurts. R #2 stated she didn't remember when her toenails were last cut. C. On 06/03/25 02:08 PM, during an interview, CNA # 25 stated nurses' trim residents' nails of residents who are diagnosed with diabetes D. On 06/04/25 10:37 AM, during an interview, LPN #26 stated she did a lot of referrals for nails and will check in R #2's chart. LPN #26 confirmed that there is not a podiatry referral in R #2's chart. E. On 06/04/25 09:47 AM, during an interview, the DON confirmed that if a resident is diabetic, they are sent to the podiatrist and if a resident is not diabetic then the expectation is nurses will trim toenails as needed. R #33 F. On 06/02/25 at 12:11 PM, during an observation of R #33's room, R #33's fingernails were long and unkept. G. Record review of R #33's admission Minimum Data Set (MDS) dated [DATE] revealed R #33 required substantial/maximal assistance for ADL care. H. On 06/04/25 at 9:44 AM, during an interview, CNA #8 confirmed that R #33's fingernails needed to be cut. CNA #8 said that staff will check residents' fingernails and toenails on shower days. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	I. On 06/05/25 at 3:50 PM, during an interview, the DON said that ADL care should be provided.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. Based on observation, record review, and interview, the facility failed to maintain appropriate staffing levels to meet the needs of the residents. This failure has the potential to affect all 98 residents (residents were identified by the resident census list provided by the Administrator on 06/01/25). This deficient practice could likely result in residents not receiving the care and service needed while in the facility. The findings are: A. On 06/02/25 at 9:14 AM during an interview with R #31 and her daughter. R #31's daughter stated that she comes in the mornings because the facility is short staffed, and staff don't give R #31 her dentures, and get R #31 situated for breakfast. R #31's daughter stated R #31's hair hasn't been washed since she entered the facility a few weeks ago. B. On 06/01/25 at 12:05 PM, during an interview, R #44 stated the following: 1. He preferred to eat food in his room. 2. When the facility is short staffed, they deliver meal trays late. 3. That morning (06/01/25), they were short staffed, it took an hour to get his breakfast and it was cold. C. On 06/02/25 at 8:42 AM during an interview, R #72 said it takes them a long time to answer the call light. R #72 said that she has asked for pain pills and that it takes staff a long time to bring them to her. R #72 said it is all shifts and sometimes it takes an hour. D. On 06/01/25 at 12:35 PM during an observation, revealed the following: 1. The medical records coordinator passed out the meal tray to R #253 for lunch. 2. The medical records coordinator entered R #253's room with meal tray and stated, I have your lunch. 3. R #253 asked to keep his food on meal tray, and the medical record coordinator stated, I'm not supposed to leave your food on the meal tray. R #253 insisted on keeping his meal tray. The medical records coordinator dropped the meal tray on R #253's bedside table. The medical records coordinator rushed out of R #253's room without further communication with R #253 and sighed heavily. 4. The medical records coordinator did not offer to set up R #253's lunch tray, and did not assist R #253 to open any containers or place the bedside table within R #253's reach. 5. R # 253 looked at this surveyor with a puzzled look on his face and stated, you saw that right? R #253 then attempted to reach for the bedside table but was unable to move it within his reach. E. On 06/01/25 at 1:30 PM during an interview, the medical records coordinator stated the facility was short staffed and she was assisting with passing meal trays. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	F. On 06/05/25 at 9:27 AM during an interview with R #253, he stated he figured the medical records coordinator was a new employee and probably shouldn't have been serving people their food. G. On 06/01/25 at 12:03 PM during an interview, R #254 said that the facility is short handed all the time, and he has to wait for assistance. R #254 said that he can't go to the bathroom on his own and that it takes staff a while to get to him. H. On 06/05/25 at 2:14 PM during an interview, R #254 said that he had an accident waiting for staff to help him go to the bathroom. R # 254 said he can't get his pants down on his own. I. On 06/05/25 at 10:32 AM during an interview, the DON said that she does the staffing. The DON said that there is one CNA and one nurse for each floor except for the 100 hall. The DON said that 2 nurses split the 100 hall. The DON said that when staff is available she will have 2 CNA's on the 200 and 600 hall. The DON said the following: - 600 hall have 17 residents and there are not any residents that need two person assist. -500 hall have 18 residents and there are 2 residents that need two person assist. -200 hall have 17 residents and there are 5 residents that need two person assist. -100 hall have 15 residents and there are 2 residents that need two person assist. - Secured hall 300 and 400 have 30 residents and there is one person that is a two person assist. The DON said that when a CNA needs help, that a CNA from another floor will assist and that the nurses help too. The DON said that her expectation is that all staff answer call lights and help if they can. The DON said that she thinks there is enough staff to take care of the residents' needs. The DON said that she has not heard any complaints about there not being enough staff. J. On 06/05/25 11:19 AM, during an interview, CNA #10 said that she picked up a shift today because they are shorthanded. CNA #10 said that there are not enough CNA's to help the residents. CNA #10 said that there is usually one per hall. CNA #10 said when they are showering residents, a CNA from another hall has to cover their hall. CNA #10 said that the residents have to wait for care. CNA #10 said when the surveyors are at the facility, everyone helps, but it isn't like that when surveyors aren't at the facility. CNA #10 said they have asked for more help but they don't get it. K. On 06/05/25 at 11:25 AM, during an interview, CNA #8 said that there is one CNA on each floor and it's not enough to take care of the residents' needs. CNA #8 said that she they have to shower, get residents up and dress, take residents to the bathroom, change residents, pass out trays, assist residents with meals, and help with any other needs the residents have. CNA #8 said that the resident care is delayed because there are not enough staff. CNA #8 said that she has to rush to get the resident's cared for. CNA #8 said that she doesn't have time to spend with the residents. CNA #8 said that residents have to wait to be changed. CNA #8 said that she is always hurrying. CNA #8 said that there are more staff now that the surveyors are here but usually it is just 1 CNA per floor and 1 nurse. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	L. On 06/05/25 at 2:51 PM, during an interview, RN #9 said that she doesn't believe there are enough CNA's. RN #9 said that CNA's are rushed and can't take time with the residents. RN #9 said that residents get frustrated because they have to wait. RN #9 said that there are four residents requiring the hoyer lift that are two persons assist and one sit to stand assist resident on the 200 hall. RN #9 said that there are two residents requiring hoyer lift and two persons assist on the 100 hall. RN #9 said that when a CNA has to leave her floor to assist another CNA, that leaves the floor without a CNA, and depending on what they are assisting with, it can be a while. RN #9 said that she will help, but it still isn't enough to give each resident the time they need with assistance. M. Record review of the facility's staffing assignment and time sheets for 05/31/25 with a census of 97 revealed the following: 1. 600 hall had 1 nurse and 1 CNA for both shifts. 2. 500 hall had 1 nurse and 1 CNA. The nurse assigned split the 100 hall on day shift. Night shift only had 1 nurse from 6:00 PM until 9:00 PM. 3. Secured unit 300 and 400 1 nurse and 2 CNA's for both shifts. 4. 200 hall had 1 nurse and 1 CNA. The nurse assigned split the 100 hall also. 5. 100 hall had 1 CNA and 2 nurses split the hall. Night shift only had 1 nurse from 6:00 PM until 9:00 PM. N. Record review of the facility's staffing assignment and time sheets for 06/01/25 with a census of 97 revealed the following: 1. 600 hall had 1 nurse and 1 CNA for both shifts. 2. 500 hall had 1 nurse and 1 CNA. The nurse assigned split the 100 hall on day shift. Night shift only had 1 nurse from 6:00 PM until 9:00 PM. 3. Secured units 300 and 400 had 1 nurse and 2 CNA's for both shifts. 4. 200 hall had 1 nurse and 1 CNA. The nurse assigned split the 100 hall also. 5. 100 hall had 1 CNA and 2 nurses split the hall. Night shift only had 1 nurse from 6:00 PM until 9:00 PM.

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, and interview, the facility failed to ensure residents received necessary behavioral health care to meet their needs for 1 (R #63) of 2 (R #14 and R #63) residents reviewed for behavioral health concerns when staff failed to ensure consistent psychiatric services. This deficient practice could likely result in residents not receiving the behavioral or mental health care and assistance needed to attain or maintain the highest practicable physical, mental, and psychosocial well-being. The findings are: A. Record review of R #63's admission record (no date) revealed the following: 1. R #63 was admitted to the facility on [DATE]. 2. R #63 diagnoses as follows: a. Unspecified dementia, moderate, with psychotic disturbance (diagnosis that encompasses a range of symptoms that lead to a decline in skills your brain uses to complete daily tasks, can cause abnormal thinking and perceptions but specific details regarding the condition are not clearly defined). b. Other recurrent depressive disorders. c. Unspecified dementia, unspecified severity, with other behavioral disturbance (confusion or mild cognitive impairment that cannot be clearly diagnosed and include consistent patterns of actions or responses that disrupt daily life). B. Record review of R #63's physician's orders revealed an order dated 07/07/23, refers to [name of psychiatric provider] for evaluation and treatment. C. Record review of R #63's Initial Psychotherapy (treatment for mental health issues by talking with a mental health provider) Assessment, dated 04/10/24 revealed the following: 1. Reason for referral: agitation, anger, anxiety, psychosis (loss of contact with reality that affects the mind and can cause delusions [strongly held false beliefs], hallucinations [seeing or hearing things that are not present], and other symptoms) aggressive behavior/verbal, sexually inappropriate behavior. 2. The purpose of psychotherapy is to alleviate emotional disturbance, improve function, and prevent deterioration. 3. Patient could benefit and has the capacity to participate in treatment. Patient is compliant. 4. Psychotherapy treatment plan: Goals for therapy include reducing symptoms of depression and preventing/reducing decline due to dementia. Psychotherapy is recommended one to four times per month. D. Record review of R #63's care plan, multiple dates, revealed the following: (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Focus: R #63 is on psychotropic medication related to depression, dementia with psychotic disturbances and behavioral disturbances. - Approaches/Tasks: Psych consult as needed. - Focus: R #63 is exhibits difficulty with behavioral issues as evidenced by anger easily. - Approaches/Tasks: Refer to Psyche(sic) - Focus: R #63 has aggressive behavior - Approaches/Tasks: investigate/monitor need for psychological/psychiatric support. E. Record review of R #63's Electronic Health Record (EHR) revealed the R #63 was not seen for any further psychotherapy visits after 04/10/24 visit. F. On 06/0524 at 4:13 PM, during an interview with the administrator, she stated the following: 1. She is not sure why R #63 was no longer seen for psychotherapy. 2. The initial visit on 04/10/24 was the only visit R #63 received for psychotherapy.

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview the facility failed to ensure a resident diagnosed with dementia (group of symptoms related to loss of memory, judgment, language, complex motor skills, and other intellectual function, caused by the permanent damage or death of the brain's nerve cells) received appropriate treatment and services to attain his highest mental and psychosocial well-being for 1 (R #33) of 1 (R #33) resident reviewed for dementia treatment and services when the facility failed to: 1. Ensure R #33's care and services are person centered and help maximize his dignity and autonomy. 2. Utilize individualized, non-pharmalogical (treatments or interventions that do not involve the use of medications or drugs) approaches to his care. This deficient practice could likely result in a lack of meaningful relationships, engagement in day-to-day activities and diminished quality of life. A. Record review of R #33's admission record, no date, revealed the following: 1. R #33 was admitted to the facility on [DATE]. 2. R #33 had a diagnosis of dementia without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety. B. Record review or R #33's care plan does not include R #33's dementia diagnosis or any care related dementia. C. Record review of R #33's orders revealed the following: 1. An order dated 05/27/25 for donepezil oral tablet 10 mg give 1 tablet via peg-tube (a feeding tube inserted through the abdominal wall directly into the stomach) at bedtime for dementia. 2. An order dated 05/27/25 for memantine oral tablet 10 mg give 1 tablet via peg-tube two times a day for dementia. 3. An order dated 05/30/25 for hydroxyzine 25 mg Give 1 capsule via peg-tube two times a day for agitation/anxiety. D. Record review of R #33's progress notes revealed the following: 1. On 03/18/25 at 12:28 pm R #33 was physically fighting to stand up from chair, throwing items, scratching, and pulling at staff. (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. On 03/18/25 at 1:16 pm R #33 tried to exit the facility, stripped all his clothes off and went into other rooms. R #33 was combative with staff when attempting to redirect. R #33 is a peg tube and NPO (nothing by mouth) and staff has been unable to feed him or provide any medications because R #22 will not allow staff to care for him and becomes combative. This nurse stated that staff will not be able to care for R #33. state he is in. This nurse notified residents nurse of the order to send to hospital 3. On 04/23/25 that multiple attempts were made by CNA and a nurse to assist R #33 into his wheelchair and encouraged him to attend activities. R #33 continuously refused. R #33 did not state reason for refusing. 4. On 05/15/25 R #33 was redirected multiple times by staff because R #33 was witnessed picking and scratching at his left cheek by this nurse. E. On 06/04/25 at 11:07 AM, during an interview, the Activities Director (AD) said that she has colored with R #33. The AD said that she takes R #33 to see the fish and will ask him if he remembers the fish. The AD said that she talks to R #33 and will ask him if he remembers her. The AD said that she has had the activity director training for dementia care and that she knows that there are memory care activities that can be done with residents with dementia but that she has not done memory games with R #33. The AD said that she did bring the memory cards out once, but R #33 was more receptive to coloring. D. On 06/04/25 at 3:06 PM, during an interview, the DON confirmed R #33's dementia diagnosis. The DON said that R #33 should be provided care that is needed to help with his memory and to maintain his health.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure the consultant pharmacist's recommendations were reviewed and implemented by the physician and/or the physician provided documentation of a rationale (set of reasons or a logical basis for a course of action) for not following the consultant pharmacist's recommendation for 3 (R #14, R #33 and R #63) of 7 (R #14, R #15, R #18, R #28, R #33, R #35, and R #63) residents reviewed for unnecessary medications. This deficient practice could likely result in residents receiving medications that are no longer necessary and may cause unnecessary drug interactions (changes to medication action caused by being combined with other foods, beverages, or drugs) or adverse side effects (unwanted, undesirable effects from medication). The findings are: R #14 A. Record review of R #14's admission record (no date) revealed the following: 1. R #14 was admitted to the facility on [DATE]. 2. R #14 had a diagnosis of other recurrent depressive disorders (mental health condition with symptoms characteristic of a depressive disorder such as persistent sadness that cause clinically significant distress but do not meet the full criteria for any other depressive disorder). B. Record review of R #14's physician's orders revealed an order dated 09/25/24 for Prozac (fluoxetine antidepressant medication primarily used to treat depression disorders) capsule 20 mg, give 1 capsule by mouth one time a day for depression. Start date: 09/16/24. C. Record review of R #14's Medication Regimen Review (form provided to the facility with pharmacist recommendation) dated 03/14/25, revealed the following: 1. Gradual dose reduction request: Medication fluoxetine (Prozac) 20 mg once daily. 2. Residents who use psychotropic drugs must have GDR attempts unless clinically contraindicated, in an effort to discontinue these drugs. Do you feel a reduction could be attempted on the above medication at this time? 3. The form was electronically signed by the pharmacist. 4. The physician response section was blank, and the form was not signed by a physician. D. Record review of R #14's Medication administration record (MAR; electronic form used by nursing staff to document when medication is given), dated 05/01/25 through 05/31/25, revealed R #14 received Prozac (fluoxetine) 20 mg every morning from 05/01/25 through 05/31/25. E. On 06/05/25 at 4:10 PM during a joint interview, the DON and the Regional Nurse Consultant (RNC) confirmed the following: 1. The pharmacist recommendation was not implemented by R #14's physician. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. R #14's physician did not provide a rationale in R #14's medical record, indicating the reason a GDR was not completed for R #14. R #33 F. Record review of R #33's admission record (no date) revealed the following: 1. R #33 was admitted to the facility on [DATE]. 2. R #33 diagnoses as follows: a. Depression, Unspecified. b. Other seizures. c. Traumatic brain injury (TBI; an injury that disrupts the normal function of the brain, typically caused by a blow or impact to the head or body). G. Record review of R #33's physician's orders, multiple dates, revealed the following: 1. Order dated 03/17/25 for duloxetine oral capsule delayed release sprinkle 60 mg give one capsule via peg tube (a feeding tube inserted directly into the stomach through the abdominal wall) two times a day for depression. 2. Order dated 03/21/25 for phenobarbital oral tablet 64.8 mg in the morning and 97.2 mg at bedtime for seizures. 3. Order dated 03/19/25 for olanzapine oral tablet 5 mg give 1 tablet enterally at bedtime for TBI. 4. Order dated 03/21/25 for trazodone hci oral tablet 100 mg give 1 tablet via peg tube at bedtime for insomnia. 5. Order dated 03/17/25 for Keppra oral solution 100 mg give 7.5 ml via peg tube two times a day for seizures. H. Record review of R #33's progress note dated 03/26/25, revealed R #33 had a fall and was on the floor in front of his wheelchair. I. Record review of a medication regimen review dated 04/09/25, revealed the following: 1. R #33 had a recent fall and that R #33's medication can increase fall risk. 2. Would physician like to make any changes to medications? 3. Please offer clinical rationale. 4. Physician documented R #33 was stable on medication. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	J. Record review of R #33's medical record revealed the following: 1. The physician did not document that the medications listed on the pharmacy recommendation were reviewed. 2. The physician did not provide clinical rationale for continuing R #33's medication. R #63 K. Record review of R #63's admission record (no date) revealed the following: 1. R #63 was admitted to the facility on [DATE]. 2. R #63 diagnoses as follows: a. Unspecified dementia, moderate, with psychotic disturbance (diagnosis that encompasses a range of symptoms that lead to a decline in skills your brain uses to complete daily tasks, can cause abnormal thinking and perceptions but specific details regarding the condition are not clearly defined). b. Other recurrent depressive disorders. c. Unspecified dementia, unspecified severity, with other behavioral disturbance (confusion or mild cognitive impairment that cannot be clearly diagnosed and include consistent patterns of actions or responses that disrupt daily life. L. Record review of R #63's physician's orders, multiple dates, revealed the following: 1. Order dated 06/14/23 for divalproex sodium oral tablet delayed release (antiseizure medication commonly used to treat seizures, bipolar disorder and to prevent migraine headaches) 250 mg, give 1 tablet by mouth three times a day for behavioral disturbances in dementia. 2. Order dated 08/14/23 for buspirone (anti-anxiety commonly used to treat symptoms of anxiety, such as fear, tension, irritability, dizziness, pounding heartbeat, and other physical symptoms) oral tablet, give 7.5 mg by mouth two times a day for sexually inappropriate behaviors (behaviors such as sexual conversation, inappropriate touching or grabbing that occur when a person has lost the ability to inhibit behavior) ordered by [name of psychiatric service provider]. 3. Order dated 07/24/24 for sertraline tablet give 100 mg by mouth one time a day for depression. M. Record review of the Psychotropic Medication Utilization Report (pharmacist spreadsheet that includes information about the use of psychotropic, sedative, and hypnotic medications), dated 03/14/25, revealed the following: 1. R #63 had an order for divalproex three times a day since 06/14/23, and a GDR was declined in September 2024. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. R #63 had an order for buspirone 7.5 mg two times a day since 08/14/23, and a GDR was declined in July 2024. 3. R #63 had an order for sertraline 100 mg one time a day since 07/24/24, and a GDR was declined in November 2024. N. Record review of R #63's MAR, dated 05/01/25 through 05/31/25, revealed the following: -divalproex 1. R #63 received divalproex 250 mg three times daily from 05/01/25 through 05/09/25. 2. R #63 received divalproex 250 mg at 8 AM on 05/10/25. 3. R #63 received divalproex 250 mg at 7 PM on 05/10/25. 4. R #63 received divalproex 250 mg three times daily from 05/11/25 through 05/31/25. -buspirone 5. R #63 received buspirone 7.5 mg two times a day from 05/01/25 through 05/31/25. -sertraline 6. R #63 received sertraline 100 mg one time a day from 05/01/25 through 05/31/25. O. On 06/05/25 at 4:20 PM, during a joint interview, the DON and the Regional Nurse Consultant (RNC) confirmed the following: 1. R #63 has not had a GDR for divalproex, buspirone or sertraline as recommended by pharmacist. 2. R #63's physician did not provide a rationale in R #63's medical record, indicating the reason a GDR was not completed for R #63 as recommended by the pharmacist.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation and interview, the facility failed to secure a treatment cart for all 69 residents who do not reside in the secure unit (residents were identified by the census list provided by the Administrator on 06/01/25). This deficient practice could result in residents obtaining medication not prescribed to them resulting in adverse side effects. The findings are: A. On 06/01/25 at 9:45 AM, an observation of the facility revealed the treatment cart was in a central location near hall 600 and was unlocked. B. On 06/01/25 at 9:45 AM, during an interview LPN #28 confirmed that the treatment cart was unlocked. C. On 06/01/25 at 9:45 AM, during an interview, with DON confirmed that treatment carts and medications carts should be secured when staff are not present.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Recite from 04/24/24 Based on observation and interview, the facility failed to store food under sanitary conditions for all 94 residents who eat food from the kitchen (residents were identified by the resident matrix provided by the administrator on (06/01/25) when staff failed label and date all items in the kitchen refrigerator. Failure to store food under safe and sanitary conditions could likely lead to foodborne illnesses in residents. The findings are: A. On 06/01/25 at 9:25 AM, an observation of the kitchen revealed the following: 1. The refrigerator had two trays with 10 lid-covered beverages, the lids were not dated. 2. The walk-in refrigerator had three trays with covered desserts on them. The desserts did not have a date to indicate when they were prepared. B. On 06/01/25 at 9:32 AM, during an interview, the Dietary Manager confirmed that the drinks and desserts should all be labeled with the date they were prepared.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** Recite from 04/24/24 Based on record review, observation, and interview, the facility failed to ensure medical records were complete and accurate for 2 (R #14 and R #35) of 4 (R #14, R #21, R #28, and R #35) residents reviewed for documentation accuracy. This deficient practice has the potential to negatively impact on the care staff provided to meet residents' needs due to missing or inaccurate records and resident information. The findings are: R #14 A. Record review of R #14's admission record (no date) revealed the following: 1. R #14 was admitted to the facility on [DATE]. 2. R #14 has a diagnosis of unspecified psychosis not due to a substance or known physiological condition (mental health disorder characterized by a loss of touch with reality, hallucinations, delusions, disordered thinking and behavioral changes that encompasses a range of disorders that do not fit into specific categories). B. Record review of R #14's physician's orders revealed an order dated 04/08/25 for Abilify (aripiprazole generic for Abilify; an antipsychotic medication that changes the actions of chemicals in the brain and is used to treat various conditions such as schizophrenia, bipolar disorder and depression) oral tablet 15 mg, give 10 mg by mouth at bedtime for unspecified psychosis not due to a substance or known physiological condition. C. Record review of R #14's Medication administration record (MAR; electronic form used by nursing staff to document when medication is given), dated 05/01/25 through 05/31/25, revealed R #14 received Abilify oral tablet 15 mg, give 10 mg by mouth at bedtime from 05/01/25 through 05/31/25. D. On 06/04/25 3:03 PM, during an observation of the medication cart for the 400 hall revealed R 14's medication blister pack (medication storage that allows for 1 dose of medication to be dispensed at a time) was labeled aripiprazole tab (tablet) 10 mg, give 1 tablet (10 mg) by mouth at bedtime. E. On 06/04/25 at 3:05 PM, during an interview, LPN #1 confirmed the following: 1. The physician's order for Abilify read: Abilify oral tablet 15 mg, give 10 mg by mouth at bedtime for unspecified psychosis not due to a substance or known physiological condition. 2. R #14's blister pack read: aripiprazole tab (tablet) 10 mg, give 1 tablet (10 mg) by mouth at bedtime. 3. The blister pack label did not match the documentation of the physician's order. R #35 (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	F. Record review of R #35's admission documents, no date, revealed the following: 1. R #35 was admitted to the facility on [DATE]. 2. R #35 did not have a diagnosis of heart failure (occurs when the heart muscle doesn't pump blood as well as it should) in her list of diagnoses in the medical record. G. Record review of R #35's history and physical (H&P, physician obtains a thorough medical history from the patient, performs a physical examination, and then documents their findings), dated 04/25/25, revealed the following: 1. R #35 had a diagnosis of chronic systolic heart failure (a serious, chronic condition that occurs when the left ventricle can't pump blood efficiently) with an onset (start) date of 11/27/24. 2. R #35 had a diagnosis of chronic diastolic heart failure (left heart ventricle doesn't relax properly between heartbeats) with an onset date of 11/02/24. H. Record review of R #35's care plan, dated 11/12/24, revealed R #35 had a diagnosis of congestive heart failure (also called heart failure). I. On 06/05/25 at 4:59 PM, during an interview, the DON confirmed the following: 1. R #35 H & P, dated 04/25/25, included a diagnosis of chronic diastolic heart failure and chronic systolic heart failure. 2. R #35's diagnoses in the medical record did not include R #35's diagnoses of chronic diastolic heart failure or chronic systolic heart failure. 3. Staff should have updated R #35's diagnoses to include chronic diastolic heart failure and chronic systolic heart failure.

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F 0851 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Electronically submit to CMS complete and accurate direct care staffing information, based on payroll and other verifiable and auditable data. Based on record review and interview, the facility failed to submit direct care staffing information to the federal agency overseeing certification for long term care facilities for July 2024 through December 2024. This has the potential to affect all 98 residents in the facility, (residents were identified by the Resident Matrix provided by the Administrator on 06/01/25). This deficient practice could likely result in inaccurate direct care staffing information for residents/facility. The findings are: A. Record review of Payroll Base Journal (PBJ) Staffing Data Report (report from the data base of the federal agency overseeing certification for long term care facilities) dated Quarter #3 and #4 2024 (July 1 through December 31) revealed low weekend staffing. B. On 06/05/25 at 9:33 AM, during an interview, the Administrator revealed that contracted staff are not being captured on the PBJ report. The Administrator stated that contract staff don't clock in and out at the facility like staff do, and their agency keeps their time. The Administrator said that they are working with the corporate office to correct the reporting.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Recite from 04/24/24 Based on observation, record review, and interview, the facility failed to maintain an infection prevention and control program designed to provide a safe and sanitary environment to prevent the development and transmission of communicable diseases and infections when staff failed to implement and follow enhanced barrier precautions (EBP, an infection control intervention) for 2 (R #15 and R #21) of 2 (R #15 and R #21) residents reviewed for infection prevention. If the facility fails to maintain an effective infection control program, then infections could spread to residents throughout the facility, resulting in illness. The findings are: A. Record Review of the [Name of Federal Agency] Enhanced Barrier Precautions in Nursing Homes to Prevent Spread of Multidrug-resistant Organisms (MDROs), dated 03/20/24, revealed the following: 1. MDRO transmission is common in long term care (LTC) facilities. 2. EBP refers to an infection control intervention designed to reduce transmission of MDRO that employs targeted gown and glove use during high contact resident care activities. a. Examples of high-contact care activities include: i. Dressing ii. Bathing/showering iii. Transferring iv. Changing linens v. Providing hygiene vi. Changing briefs or assisting with toileting vii. Device care or use: Central line, urinary catheter, feeding tube, or tracheostomy viii. Wound Care: any skin opening requiring a dressing 3. EBP are indicated for residents with wounds or indwelling medical devices, even if the resident is not known to be infected or colonized with a MDRO. R #15 B. Record review of R #15's admission documents, no date, revealed the following: 1. R #15 was admitted to the facility on [DATE]. (continued on next page)

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	06/05/2025

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.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. R #15 had the following diagnoses: a. Dysphagia, oropharyngeal phase (swallowing problems occurring in the mouth and/or the throat). b. Dysphagia following cerebral infarction (swallowing problems after a stroke). c. Gastrostomy status (a surgical opening into the stomach for nutritional support). C. Record review of R #15's physician's order, dated 03/11/25, revealed an enteral feed (a way of sending nutrition right to the stomach or small intestine through a feeding tube (medical device used for people who cannot swallow safely) order three times a day, to check for residual (the volume of fluid remaining in the stomach at a point in time during enteral nutrition feeding) before medication administration. D. On 06/04/25 at 08:09 AM, during an observation of medication administration to R #15 in her room, revealed the following: 1. R #15 had an EBP sign on her door. 2. R #15's EBP sign had the instructions, staff must wear gown and gloves for all high- contact resident care activities. 3. R #15 had a peripherally inserted gastrostomy tube (PEG, feeding tube) to her left abdomen. 4. LPN #16 did not put on a gown when she administered medications through R #15's PEG tube. E. On 06/04/25 at 8:59 AM, during an interview, LPN #16 stated the following: 1. She had been trained on EBP. 2. She was not aware that it was mandatory to wear a gown when working with residents on EBP. R #21 F. Record review of R #21's administration, no date, revealed R #21 was admitted to the facility on [DATE]. G. Record review of R #21's physician's orders, multiple dates, revealed the following: 1. Order dated 05/31/25, for wound care to R #21's left hip. 2. Order dated 05/23/25, for wound care to R #21's right foot. 3. Order dated 05/29/25, for wound care to R #21's right iliac crest (the curved area at the top of the ilium bone, the largest of three bones that make up the pelvis). 4. Order dated 05/21/25, for wound care to R #21's right lower back. (continued on next page)

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	06/05/2025

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	H. On 06/04/25 at 11:00 AM, during an observation of R #21's room, there was no EBP sign on her door. I. On 06/04/25 at 11:13 AM, during an interview, the wound care nurse stated the following: 1. R #21 was not on any transmission based precautions (TBP, the second tier of basic infection control and are to be used in addition to Standard Precautions for patients who may be infected or colonized with certain infectious agents for which additional precautions are needed to prevent infection transmission). 2. She wears personal protective equipment (PPE, equipment worn to minimize exposure to a variety of hazards) when performing wound care for R #21. J. On 06/05/25 at 4:06 PM, during an interview, the infection preventionist, stated the following: 1. Residents who are receiving wound care should be on EBP. 2. Residents with wounds only need EBP when performing wound care. 3. The wound care nurse uses a treatment cart that has the PPE needed for wound care. 4. Resident's with wounds do not have an EPB sign on their door since the wound care nurse has all the PPE she needs on the cart. 5. Staff should wear gown, gloves, and goggles when administering medications through a resident's PEG tube. 6. She trains staff on EBP and all other TBP. K. On 06/05/25 at 4:56 PM, during an interview, the DON confirmed the following: 1. Staff should wear appropriate PPE when performing high contact patient care for residents on EBP. 2. All residents with wounds should be placed on EBP. 3. An EBP sign should be on the resident's door and the appropriate PPE located in the resident's room so staff can put on the PPE when performing high contact patient care.