STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	325058	A. Building B. Wing	11/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Grants Wellness & Rehabilitation LLC	840 Lobo Canyon Road Grants, NM 87020

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, record review, and interview, the facility failed to promote care with dignity and respect for 1 (R #33) of 1 (R #33) residents when R #33 was found sitting in the dining room during lunch with an active bleeding wound on his hand, which included blood on his clothing, face, and both hands. This deficient practice is likely to result in residents feeling unimportant to facility staff and an increased risk of infection due to being around other residents in the dining room. The findings are: A. Record review of R #33's face sheet revealed a re-admission date of 08/18/25 and included a diagnoses of cognitive communication deficit (difficulties in communication that arise from impaired cognitive functions, such as attention, memory, reasoning, and problem solving) and degenerative disease of nervous system (conditions that gradually damage and destroy parts of your nervous system, especially areas of the brain). B. Record review of R #33's annual Minimum Data Set (MDS; a federally mandated assessment instrument completed by facility staff) dated 05/29/25, revealed R #33 had a Brief Interview of Mental Status (BIMS; a screening for cognitive impairment) of 2 (severe impairment).- Scores range from 00 to 15, with 15 - 13 is cognitively intact, 12 - 8 is moderately impaired, 7 - 00 is severe impairment.C. On 09/30/25 at 12:14 pm, an observation (approximately 30 minutes) revealed the following:- R #33 had blood on the top of his right hand; staff served his tray and then walked away.- R #33 had blood on his left hand and clothing.- R #33 had a wound on his right hand that was actively bleeding.- R #33 was feeding himself with his hands while they were still bloody.- R #33 was picking butter out of the single-serve butter cups with his bloody hands.D. On 09/30/25 at 12:45 pm during an interview, the Director of Nursing (DON) verified R #33 had an open actively bleeding wound, and he had blood on both hands and clothing. The DON stated it was not an acceptable practice for R #33 to be seated in the dining room in that condition. She stated the active bleeding wound on his right hand should have been cleansed and covered, and the staff who served his meal should have cleaned R #33's wound instead of walking away.

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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. Based on record review and interview, the facility failed to ensure residents or their guardians were aware of the medications they received including the reasons, risks, and benefits of each medication for 2 (R #10 and #13) of 3 (R #10, #13 and #44) residents reviewed for unnecessary medications. If residents and/or their guardians are not informed of the risks and benefits of each medication, then they are not able to make informed decisions. The findings are: R #10A. Record review of R #10's physicians' orders revealed the following:- 07/11/25: Escitalopram Oxalate oral tablet (antidepressant), 20 mg by mouth one time a day for depression.- 10/02/25: Depakote oral tablet (anticonvulsant), delayed release, 500 milligrams (mg) by mouth two times a day for anxiety related to traumatic brain injury (TBI; injury to the brain caused by an outside force, usually a violent blow to the head). Start date: 10/02/25.- 10/11/25: Quetiapine Fumarate oral tablet (antipsychotic), 150 mg by mouth at bedtime for anxiety related to TBI and anxiety.- 11/17/25: Hydroxyzine HCl oral tablet (antianxiety), 25 mg by mouth every 6 hours as needed for agitation and anxiety.B. Record review of R #10's electronic medical record (EMR) revealed the record did not contain a consent form from the resident/responsible party for Depakote 500 mg, Escitalopram 20 mg, Hydroxyzine 25 mg, and Quetiapine 150 mg. C. On 11/18/25 at 1:50 pm during an interview, the Director of Nursing (DON) stated there should be a signed consent form for R #10's anticonvulsant, antidepressant, antianxiety and antipsychotic medications.R #13D. Record review of R #13's physicians' orders revealed the following: - 10/03/25: Citalopram Hydrobromide (increases the amount of serotonin in the brain and helps maintain mental balance) oral tablet, 20 mg by mouth one time a day for depression. - 10/13/25: Hydroxyzine Pamoate Please define oral capsule, 25 mg by mouth two times a day for anxiety related to dementia. E. Record review of R #13's Electronic Medical Record (EMR) revealed the record did not contain a consent form from the resident/responsible party for Citalopram 20 mg and Hydroxyzine 25 mg. F. On 11/18/25 at 1:50 pm during an interview, the Director of Nursing (DON) stated there should be a signed consent form for R #13's anticonvulsant, antidepressant, antianxiety and antipsychotic medications.

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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 Based on record review and interview, the facility failed to develop and implement an adequate 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 2 (R #10 and #44) of 3 (R #2, #10 and #44) residents reviewed for baseline care plans. If the facility fails to develop and implement an adequate baseline care plan within 48 hours of admission for residents, then staff may lack necessary guidance to provide appropriate care which could lead to an adverse event (undesirable experience, preventable or non-preventable, that causes harm to a resident due to medical care or lack of medical care). R #10A. Record review of R #10's face sheet revealed an admission date of 07/05/25 and included the following diagnoses: - Urinary tract infection (UTI; an infection in any part of the urinary system, which includes the kidneys, ureters, bladder, and urethra).- Type 2 diabetes (DM2, a condition which results from insufficient production of insulin, causing high blood sugar).- Depression (a mood disorder that causes a persistent feeling of sadness and loss of interest).- Anxiety disorder (feelings of fear or apprehension).- Polyneuropathy (a condition that damages multiple peripheral nerves in the body).- Blindness, both eyes.- Hypertension (HTN; high blood pressure).- Esophageal varices (abnormal veins that usually develop when the blood to the liver is blocked).- Constipation (bowel movements either occur less often than expected or the stool is hard, dry, and difficult to pass).- Alcoholic cirrhosis of liver (the most advanced form of liver disease related to excessive alcohol consumption).- Muscle wasting and atrophy (loss of muscle mass and strength).- Reduced mobility.- Traumatic Brain Injury (TBI; injury to the brain caused by an outside force, usually a violent blow to the head). B. Record review of R #10's baseline care plan dated 07/09/25 revealed there was no baseline care plan in place within 48 hours, as it was developed four days after R #10's admission date. C. On 11/18/25 at 1:50 pm during an interview, the Director of Nursing (DON) stated R #10's baseline care plan should have been completed within 48 hours.R #44D. Record review of R #44's face sheet revealed an admission date of 09/16/25 and include the following diagnoses:- Sequelae of cerebrovascular disease (residual effects of a stroke).- Klebsiella pneumoniae (type of bacteria that can cause pneumonia, UTIs, wound infections and more).- Anemia (low red blood cell count).- Type 2 diabetes mellitus (DM2, a condition which results from insufficient production of insulin, causing high blood sugar).- Hyperlipidemia (a condition in which there are high levels of fat particles in the blood; high cholesterol).- Dementia with psychotic disturbance (a group of conditions characterized by impairment of at least two brain functions, such as memory loss and judgment with disconnection from reality).- Depression (a mood disorder that causes a persistent feeling of sadness and loss of interest).- Blindness, both eyes.- Hypertension. (HTN; high blood pressure).- Stage 3 Chronic kidney disease (CKD; impaired kidney function).- Urinary tract infection (UTI; an infection in any part of the urinary system, which includes the kidneys, ureters, bladder, and urethra).E. Record review of R #44's baseline care plan dated 09/17/25, revealed the care plan did not address the following:- Dementia with psychotic disturbance.- Klebsiella pneumoniae. - Blindness.- Sequelae of cerebrovascular disease. F. On 11/18/25 at 1:50 pm during an interview, the DON stated dementia, blindness and any type of serious infection should be addressed in the baseline care plan for R #44. She stated it is her expectation that baseline care plans be completed timely and should include anything that would affect resident's health and safety.

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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. Based on record review, observations, and interview, the facility failed to ensure the comprehensive care plan was complete for 1 (R #10) of 3 (R #10, #13 and #44) residents reviewed for care plan accuracy. This deficient practice could likely result in staff not understanding and implementing the most appropriate interventions and treatments for residents. The findings are: A. Record review of R #10's face sheet revealed an admission date of 07/05/25 and included diagnoses of blindness and depression. B. Record review of R #10's comprehensive care plans 07/09/25 revealed there was no care plan addressing activities for R #10. C. On 09/30/2025 at 2:48 pm, during an interview, R #10 stated he listens to music and the tv for entertainment but would participate in bingo if someone would help him. He stated he walks throughout the hallway to keep busy sometimes. D. On 11/18/25 at 1:50 pm during an interview, the Director of Nursing (DON) stated it is the Activities Department's responsibility to create a care plan addressing activities and wasn't sure why one had not been developed. She stated R #10 uses his phone for entertainment. She stated that facility staff download audio files to R #10's cell phone, and he also enjoys sitting next to the television when there is a football game on. E. On 11/18/25 at 2:13 pm during an observation, R #10 walked into the small dining room where residents were playing bingo; he asked what was going on in the room, staff advised him it was bingo and then R #10 walked out of the room back into the hallway.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. Based on record reviews and interview, the facility failed to:Demonstrate its measures to minimize the risk of Legionella (bacteria naturally found in water that can cause a severe type of lung infection called legionnaires' disease when people inhale tiny water droplets containing the bacteria) in the building's water system, when the Water Management Program (WMP) team failed to develop and implement an adequate Legionnaires Water Management Program (LWMP). If the facility does not have a an adequate LWMP, then residents can be at risk of legionellosis (legionnaires' disease and Pontiac fever, a milder flu-like illness). These failures had the potential to affect all residents in the facility. The findings are:A. Record review of the facility's LWMP, last revised on 06/2020, showed the following: - The policy did not have a procedure on how to use the control measures to control the introduction and/or spread of Legionella in the building water system. - The policy did not include control limits (the maximum value, minimum value, or range of values that are acceptable for the control measures that you are monitoring to reduce the risk for legionella growth and spread) and parameters. - The policy did not have monitoring procedures to include specified and documented environmental testing protocols for legionella and established control limits acceptable for the control measures the facility monitored to reduce the risk for Legionella growth and spread. - The policy did not have established ways to intervene when control limits were not met or when there was a case of healthcare-associated legionellosis in the facility. B. On 11/18/25 at 11:00 am, during an interview with the facility's Administrator, Director of Nursing, Corporate Nurse, Corporate Maintenance Director, and the Infection Control Preventionist, they stated they were not aware the LWMP was inadequate to prevent the growth and spread of legionella in the building water system. They stated they were not aware the plan did not have procedures to explain how to use the control measures, what were the acceptable control limits and parameters, what were the monitoring procedures, what were the testing protocols, and what were the established ways to intervene when control limits were not met or when there was a case of healthcare-associated legionellosis in the facility.