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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 325068 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 01/07/2025 |
| NAME OF PROVIDER OR SUPPLIER Belen Meadows Healthcare and Rehabilitation Center | | STREET ADDRESS, CITY, STATE, ZIP CODE 1831 Camino Del Llano Belen, NM 87002 | |

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) |
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| <p>F 0559</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>Honor the resident's right to share a room with spouse or roommate of choice and receive written notice before a change is made.</p> <p>34439</p> <p>Based on interview, the facility failed to inform residents and resident representatives in writing of a room change, including the reason for the change, when residents changed rooms due to a flooding event. for 8 (R #1-8) of 8 (R #1-8) residents that were moved. This deficient practice is likely to result in frustration and confusion for residents. The findings are:</p> <p>A. On 01/07/25 at 10:20 am during an interview with Nurse Manager (NM) #1, she stated the Managers were called into the facility because of the flooding on the 200 wing on 01/06/25. She stated the Managers were asked to assist in moving residents. She stated she assisted moving residents R #5 and R #3. She stated she did not call the residents' families or the resident representatives to inform them of the move or of the flooding issue. NM #1 states she was not aware if any staff called the families or resident representatives of R #1-8 to inform them of the move and flooding.</p> <p>B. Record Review of R #6's medical record revealed staff documented the following:</p> <p>- Dated 1/7/2025 at 11:15 am, due to water/ plumping issue, the resident was moved to another hall for safety. Staff notified the resident's POA/son on this date. No further questions or concerns at this time.</p> <p>- The record did not contain documentation that staff notified the POA in writing of the room change to include the reason for the change.</p> <p>C. On 01/07/25 at 11:57 am during an interview with R #6's family member, he stated the facility notified him about R #6's room change on 01/07/25 at 10:00 am.</p> <p>D. Record Review of R #3's medical record revealed the record did not contain documentation staff notified the resident or resident representative in writing regarding the room change to include the reason for the change.</p> <p>E. On 01/07/25 at 12:28 pm during a phone interview with R #3's Power of Attorney (POA; legal authorization for a designated person to make decisions about another person's property, finances, or medical care), she stated the facility did not notify her of R #3's room change, and she would have liked to know what was going on with R #3.</p> <p>(continued on next page)</p> |

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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| <p>F 0559</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>F. Record Review of R #4's medical record revealed the record did not contain documentation staff notified the resident or resident representative in writing regarding the room change to include the reason for the change.</p> <p>G. On 01/07/25 at 12:45 pm during interview with R #4, she stated staff asked her to move rooms, but the did not tell her why she was moving.</p> <p>H. Record Review of R #1's medical record revealed the record did not contain documentation staff notified the resident or resident representative in writing regarding the room change to include the reason for the change.</p> <p>I. Record Review of R #2's medical record revealed staff documented the following:</p> <ul style="list-style-type: none"> - Dated 1/7/2025 at 10:59 am, due to water/ plumbing issue, staff attempted to move the resident to a room that did not have a water issue. The resident refused to move rooms. Staff re-attempted on this date, and the resident agreed to move. - The record did not contain documentation that staff notified the POA in writing of the room change to include the reason for the change. <p>J. Record Review of R #5's medical record revealed staff documented the following:</p> <ul style="list-style-type: none"> - Dated 1/7/2025 at 11:12 am, due to water/ plumbing issue, the resident was moved to another hall for safety. Staff notified the resident's POA on this date, but she was not available at this time. Staff left a message for a call back. - The record did not contain documentation that staff notified the POA in writing of the room change to include the reason for the change. <p>K. Record Review of R #7's medical record revealed the record did not contain documentation staff notified the resident or resident representative in writing regarding the room change to include the reason for the change.</p> <p>L. Record Review of R #8's medical record revealed the record did not contain documentation staff notified the resident or resident representative in writing regarding the room change to include the reason for the change.</p> <p>M. On 01/07/25 at 1:38 pm during an interview with the Director of Nursing (DON), she stated 18 residents resided on the 200 wing. She stated seven residents were able to ambulate on their own, and those were the residents that moved to other units of the facility. The DON stated staff notified the families of all the residents that were moved on 01/07/25 by 1:00 pm by phone, but staff did not provide documentation in writing. The DON stated the flooding issue started on 01/06/25, and residents were moved on 01/06/25. The DON stated the families for R #1-8 were not notified in writing at that time.</p> | | |