STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	325068	A. Building B. Wing	11/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Belen Meadows Healthcare and Rehabilitation Center	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)
F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are fully informed and understand their health status, care and treatments. (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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record and interview, the facility failed to allow a resident to choose the time wound care would take place for 1 (R #123) of 1 (R #123) resident. This deficient practice could likely contribute to the resident not receiving wound care, which could cause the wound to worsen or become infected. The findings are:A. Record review of R #123's medical record indicated R #123 was admitted to the facility on [DATE] with the following diagnoses:-Quadriplegia (paralysis of all four limbs),-Chronic pain,-Anxiety,- Depression,- Chronic sacral (the portion of the spine between the lower back and the tailbone) pressure ulcer (PU; an injury to skin and underlying tissue resulting from prolonged pressure on the skin). B. Record review of R #123's physician orders, dated 08/12/25, revealed an order for wound care to the coccyx (tail bone). Apply triad paste (helps with wound care) mixed with Collagen particles (collagen particles are effective in promoting wound healing by enhancing tissue regeneration) to wound. Do not scrub to remove paste. Wipe away soiled layer of paste and then apply a fresh layer, two times per day every day and night shift. C. Record review R #123's Treatment Administration Record (TAR), dated 08/12/25 to 08/23/25, indicated staff administered wound care to R #123 eight out of 11 opportunities on the day shift and three out of 11 opportunities on the night shift. D. Record review of R #123's nursing progress notes revealed the following:- Dated 08/13/25 at 2:15 am, Certified Nursing Assistant (CNA) and the Nurse went to change R #123 and to turn him. The CNA and Nurse were going to perform wound care for the resident at the same time. R #123 refused to have the wound care done and stated, That's very unprofessional to do the wound care at 2:00 am. R #123 stated he would talk to the Supervisor in the morning, because it was unprofessional for wound care to be done at 2:00 am. - Dated 08/14/25 at 3:17 am, wound care to the coccyx was refused. R #123 requested wound care to be done twice per day during the morning hours to 6 pm. - Dated 08/15/25 at 3:57 am, wound care to the coccyx was refused. R #123 requested wound care to be done in the a.m. - Dated 08/15/25 at 9:35 am, R #123 was seen today to discuss recent refusals of wound care. Per resident, the wound was fine and did not require wound care as often as currently ordered. Education was provided on the current treatment plan. Triad paste was currently ordered two times per day (BID) and as needed (PRN). Education was provided to the resident on the importance of keeping the skin well lubricated with the Triad to prevent further injury to the skin.- Staff did not document a progress note on 08/16/25 to indicate why wound care did not take place on day shift or why wound care was refused by R #123 on the night shift. - Dated 08/17/25 at 1:01 am, R #123 refused wound care to the coccyx as ordered. - Dated 08/18/25 at 2:31 am, R #123 refused wound care to the coccyx multiple times and wanted it to be done during day shift only. - Dated 08/19/25 at 2:21 am, R #123 refused wound care to the coccyx multiple times and wanted it to be done during day shift only. - Dated 08/20/25 at 12:05 am, R #123 refused wound care to the coccyx multiple times and wanted it to be done during day shift only. - Dated 08/21/25 at 1:30 am, R #123 refused wound care to the coccyx multiple times and wanted it to be done during day shift only. E. On 09/19/25 at 10:00 am, during an interview, the Director of Nursing (DON) stated R #123 was difficult and refused care a lot. She stated if a resident verbalized they did not want wound care done at a certain time, then staff should get a hold of team lead, the wound care nurse, or the physician to tell them. The DON stated if the wound dressing was missing or soiled, then wound care would have to be done. She stated if it was the resident's preference to change the wound care time, then her expectation would be to accommodate the resident and have it done earlier, not at night. The DON stated some residents did not mind receiving wound care during the evening or night shift. F. On 09/19/25 at 10:15 am, during an interview, Unit Manager (UM) #2 stated R #123 was non-compliant with wound care and did not want it done at night. She stated they addressed the issue with the resident, but she could not remember how they addressed it. G. Record review of R #123's electronic medical record revealed the record did not contain any documentation in the progress notes, care plan, or in the orders regarding a discussion or a completion of a change in the time of R #123's wound care.