Department of Health & Human Services
Centers for Medicare & Medicaid Services

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Form Approved OMB
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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	02/10/2026

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure an alleged incident involving an unwitnessed fall with potential injury was reported to the State Agency (SA) for 1 (R #1) of 1 (R #1) resident reviewed for incidents. This failure compromised the State Agency's ability to triage and investigate allegations promptly, which may impact the overall effectiveness of the facility's abuse prevention system.The findings are:A.?Record review of the facility's Abuse Prohibition policy revised on 11/14/25, revealed the facility prohibits neglect and requires immediate reporting, investigation, documentation, and follow-up of alleged injuries including injuries of an unknown source. The policy defines neglect as failing to provide care or services necessary to prevent harm and directs the center to: Initiate an investigation within twenty-four hours when the facility receives information about an injury or suspected neglect,Document interviews and findings in the facility tracking system,Notify the physician and resident representative, Submit findings of completed investigations within five days to the State Agency. B. Record review of R #3's face sheet revealed R #3 was admitted into the facility on [DATE] with the following diagnoses:Dementia (a group of conditions characterized by impairment of at least two brain functions, such as memory loss and judgment),Muscle weakness (reduction in the power exerted by muscles),Major Depression (a mental health disorder characterized by persistently depressed mood or loss of interest in activities, causing significant impairment in daily life).\C. Record review of R #3's progress notes dated 01/03/26 revealed R #3 had an unwitnessed fall in her room in the morning, resulting in a swollen left hand. R #3 had a Telehealth appointment with a provider, and the provider ordered an x-ray (a picture taken inside the body to check for broken bones or injuries) for R #3's swollen left hand. D. Record review of R #3's x-ray report dated 01/05/26 revealed R #3's hand did not have breaks or a dislocation present.E. On 02/10/26 at 10:13 a.m., during an interview with the Director of Nursing (DON), she stated staff completed a head-to-toe assessment on R #3 and notified the provider following R #3's fall. The DON stated an unwitnessed fall with R #3's left hand swelling, with an X-ray to rule out injury, would require reporting to the State Agency due to the potential for injury.F. On 02/10/26 at 11:36 a.m., during an interview with the Administrator (ADM), she stated she was aware of R #3's unwitnessed fall. The ADM stated the facility should have reported R #3's fall with injury to the SA, but that did not happen.

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