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	07/02/2026

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** Based on record review and interviews, the facility failed to notify the resident for several weeks about a significant health-related test result for 1 (R #1) of 1 (R #1) resident. Failure to provide timely notification of a significant healthˆrelated finding is likely to result in delayed awareness, frustration, and may contribute to delayed or inadequate treatment. The findings are: A. Record review of R #1's face sheet revealed an admission date of 01/18/26 with the following diagnoses: Ileostomy (a surgical procedure in which the last part of the small intestine (ileum) is connected to the abdominal wall and an opening (stoma) is created in the abdominal wall created to allow waste to leave the body).Scoliosis (abnormal side-to-side curvature of the spine).Fibromyalgia (chronic muscle pain).[NAME] disease (autoimmune disorder that attacks the thyroid). B. Record review of R #1's nursing progress notes, dated 04/27/26, revealed R #1 was discharged to the hospital on [DATE] after experiencing a change in condition (CIC; any noticeable alteration in a resident's physical, mental, or functional status that may indicate a new or worsening health issue and requires timely assessment and reporting), including abnormal vital signs (body temperature, pulse rate, respiration rate, oxygen saturation, and blood pressure). R #1 was diagnosed with pneumonia (infection and inflammation of the lung) at the hospital and returned to the facility on [DATE]. C. Record review of R #1's provider follow up note, dated 05/05/26, revealed the facility nursing staff was instructed to obtain a stool sample for Clostridium difficile (C-diff; a spore-forming bacterium that causes diarrhea and inflammation of the colon, often triggered by antibiotic use) because R #1 had recently been treated with antibiotics for pneumonia and diarrhea. D. Record review of R #1's physician orders, dated 05/05/26, revealed an order for nursing staff to collect a stool sample from R #1 for a fecal occult blood test (FOBT; a diagnostic test used to detect hidden blood in the stool, which may indicate underlying gastrointestinal conditions) for Cˆdiff. E. Record review of R #1's laboratory test results (medical procedures in which a sample of blood, urine, saliva, or other bodily fluids is collected and analyzed in a laboratory to evaluate a person's health), dated 05/06/26, revealed the FOBT was positive, indicating blood was present in R #1's stool. F. Record review of R #1's provider follow up note, dated 06/09/26, did not indicate that R #1 was notified of the positive FOBT, which showed blood in her stool. G. Record review of R #1's provider encounter note, dated 06/17/26, revealed R #1 was notified of the positive FOBT collected on 05/05/26, with a recommendation for a gastrointestinal evaluation (a series of tests and examinations used to determine the causes of gastrointestinal symptoms) and a colonoscopy (a procedure using a flexible fiberˆoptic instrument inserted through the anus to examine the colon). R #1 reported frustration because she was not notified of the FOBT results sooner than 06/17/26. H. On 07/01/26 at 11:20 am, during an interview, R #1 stated she was not notified for a long time of the FOBT results collected on 05/05/26. R #1 stated she is not always notified of important changes in her care, and she should be. I. On 07/02/26 at 10:58 am, during an interview, the Director of Nursing (DON) stated residents should be informed in a timely manner of important changes in their care. The DON stated R #1 was not informed of the FOBT results collected on 05/05/26 until 06/17/26.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0691 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate colostomy, urostomy, or ileostomy care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interviews, the facility failed to provide care consistent with professional standards for 1 (R #1) of 1 (R #1) resident who requires colostomy (a surgical procedure in which the colon is connected to the abdominal wall and an opening (stoma) is created in the abdominal wall created to allow waste to leave the body) care, when the facility nursing staff were unaware of the expectations for colostomy bag (a pouch attached to the body that collects fecal waste) care and insisted R #1 could perform her own colostomy care. If the facility does not provide care consistent with professional standards for a resident with a colostomy, residents are likely to experience frustration from not receiving the care they need. The findings are: A. Record review of R #1's face sheet revealed an admission date of 01/18/26 with the following diagnoses: Ileostomy (a surgical procedure in which the last part of the small intestine (ileum) is connected to the abdominal wall and an opening (stoma) is created in the abdominal wall created to allow waste to leave the body).Scoliosis (abnormal side-to-side curvature of the spine).Fibromyalgia (chronic muscle pain).[NAME] disease (autoimmune disorder that attacks the thyroid). B. Record review of R #1's physician orders, dated 01/20/26, revealed the facility nursing staff are required to change R #1's colostomy appliance (the entire containment system used to collect waste) one time a day, every three days, and as needed. R #1's physician order required the facility nursing staff to perform colostomy care during both day and night shifts, and as needed. C. Record review of R #1's grievance, dated 06/23/26, revealed R #1 reported she was not receiving assistance with her colostomy bag. D. Record review of R #1's care plan, dated 06/24/26, revealed the facility nursing staff are required to monitor the skin around R #1's colostomy stoma to ensure it remains clean and free of irritation, and to change the appliance as needed. E. Record review of R #1's nursing progress notes, dated 06/24/26 at 7:01 am, revealed on 06/23/26 a Certified Nursing Assistant (CNA) reported R #1 might file a grievance against her because R #1 had repeatedly complained about needing help emptying her colostomy bag. The CNA stated R #1 should empty the bag herself because she was independent and able to do so. The CNA was told R #1 has tremors (an involuntary quivering movement) and could not empty the bag by herself. The CNA insisted R #1 could perform the task and stated she had witnessed R #1 emptying the colostomy bag. The CNA was reminded that R #1 has episodes of shaking, which is why she requests assistance. R #1 was upset because she and the CNA argued about emptying the colostomy bag. F. On 07/01/26 at 11:20 am, during an interview, R #1 stated the facility nurses do not help her with her colostomy bag. She stated she used to manage it independently, but she shakes now, and the tremors make it difficult. R #1 was observed shaking due to tremors. G. On 07/02/26 at 11:30 am, during an interview, the Speech Therapist (ST) stated R #1 has complained to her about not receiving help with her colostomy bag. The ST stated R #1 told her there have been times when the colostomy bag was full and needed to be emptied, but the nurses did not assist her. H. On 07/02/26 at 11:45 am, during an interview, the Director of Nursing (DON), stated when the facility received R #1's grievance on 06/23/26, the CNA was suspended immediately. She stated she reviewed the nursing progress note dated 06/24/26 regarding R #1 performing her own colostomy care. The DON stated the nurse who wrote the progress note should have reported the issue to management instead of documenting it in a nursing progress note that was not reviewed for an extended period of time. She stated when she spoke with the nurse and the CNA mentioned in the nursing progress note, there was confusion about what CNAs can and cannot do regarding colostomy care. The DON stated CNAs should empty colostomy bags for residents who use them. I. On 07/02/26 at 11:55 am, during an interview, the Unit Manager (UM) #1 stated it does not matter whether R #1 previously performed her own colostomy care, because colostomy care must be provided by the facility's nursing staff.