

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  11/18/2025
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.			
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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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<p>F 0552</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 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.</p>		

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<p>F 0584</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 a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observations and interviews, the facility failed to maintain a safe, comfortable, and homelike environment when staff failed to: - Maintain the dining room in a homelike manner.- Maintain resident rooms and bathrooms in good repair.-Maintain a resident bathroom free of flies.This failure had the potential to affect all residents who utilized the dining room and all residents in eight resident rooms. If the facility does not ensure resident rooms and common areas are clean, free from pests, and maintained in good repair, then residents are at risk of decreased quality of life, pest infestation, and injury due to unsafe environmental conditions. The findings are:</p> <p>Dining Room</p> <p>A. On 09/15/25 at 8:25 am, observations revealed the following:</p> <ul style="list-style-type: none"> <li>- Seven fluorescent light bulbs located around the walls were burnt out.</li> <li>- One chandelier bulb was burnt out.</li> <li>- All four walls had scuff marks with missing paint.</li> <li>- Several slats were missing from the wooden blinds in the windows.</li> </ul> <p>B. On 09/19/25 at 1:30 PM, during an interview, the Maintenance Director stated he was responsible for maintaining the dining room. He stated the lights in the dining area should be operational, the walls should not be scuffed, and the blinds should be fixed.</p> <p>Resident Rooms and Bathrooms</p> <p>C. On 09/15/25 at 10:00 am, observations revealed the following:</p> <p>&amp;ndash; Resident occupied room [ROOM NUMBER]: The hot water at the bathroom faucet did not turn on when the faucet was turned. Further observation revealed a white towel on the floor and pushed up under the air conditioner unit.</p> <p>&amp;ndash; Resident occupied room [ROOM NUMBER]: The floor in the bathroom had broken tiles. The sink was filled with water and drained slowly. Standing water and discolored tiles on the floor near the toilet. The walls were scuffed with missing paint.</p> <p>&amp;ndash; Resident occupied room [ROOM NUMBER]: Large cracks extended across the floor into the bathroom shared with room [ROOM NUMBER]. The bathroom sink filled with water and drained slowly. The bathroom had a foul odor.</p> <p>&amp;ndash; Resident occupied room [ROOM NUMBER]: The bathroom door was difficult to open due to the floor crack. Multiple tiles were risen off the floor and created an uneven walking surface.</p> <p>(continued on next page)</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>D. On 09/15/25 at 10:25 AM, during an interview, the resident in room [ROOM NUMBER] stated she placed towels under her air conditioning unit because water leaked into her room when it rained and created a slipping hazard.</p> <p>E. On 09/15/25 at 10:45 AM, during an interview, the residents in rooms [ROOM NUMBERS] stated they shared the bathroom. They reported the sink did not drain properly, standing water was present around the toilet, and the bathroom had a persistent foul odor. They stated they reported the concerns to maintenance, but the repairs were not completed.</p> <p>F. On 09/16/25 at 9:34 am, during an observation, the bathroom faucet located in resident occupied room [ROOM NUMBER] was broken, and the water ran continuously. Further observations on 09/17/25 at 10:18 am, 09/18/25 at 9:00 am, and 09/19/25 at 11:55 am, revealed the water ran continuously in the resident's bathroom.</p> <p>G. On 09/17/25 at 10:20 am, during an observation, room [ROOM NUMBER] had a broken window with a horizontal crack, and tape covered the crack.</p> <p>H. On 09/18/25 at 9:11 am, during an observation, a bed located in room [ROOM NUMBER] had a broken footboard on the bed. Further observation revealed the window screen was half detached from the frame, and the window was open.</p> <p>I. On 09/19/25 at 11:18 am, during interview, Certified Nurse Aide (CNA) #1 stated if a hazard was in a resident's room, then she would report it to maintenance staff right away by completing a work order. CNA #1 stated she did not observe or receive any complaints regarding broken faucets, broken footboard, or partially detached window screen. She stated the hazards could result in an uncomfortable environment for residents.</p> <p>J. On 09/19/25 at 1:30 PM, during an interview, the Maintenance Director stated he was responsible for maintaining the resident rooms. He stated he was aware of the concerns in some of the resident rooms, but the repairs were not completed. He stated room [ROOM NUMBER] experienced water intrusion during a rainstorm, and the resident placed a towel under the air conditioner. He stated the issues should have been corrected.</p> <p>Flies</p> <p>K. On 09/16/25 at 9:34 am, observation of R #55's room revealed eight flies in the restroom.</p> <p>L. On 09/17/25 at 10:18 am, observation of R #55's room revealed 12 flies in the restroom.</p> <p>M. On 09/18/25 at 9:00 am, observation of R #55's room revealed 12 flies in the restroom.</p> <p>N. On 09/19/25 at 11:55 am, observation of R #55's room revealed eight flies in the restroom.</p> <p>O. On 09/18/25 at 9:04 am, during an interview, R #55 stated she used the restroom, and there were always flies present. R #55 stated she once counted 15 flies in her restroom. She stated she preferred not to have flies in her bathroom.</p> <p>(continued on next page)</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>P. On 09/19/25 at 11:18 am, during interview, Certified Nurse Aide (CNA) #1 stated she did not observe any flies in R #55's room, and she did not receive any complaints regarding flies. She stated the flies could create an uncomfortable environment for resident.</p> <p>Q. On 09/19/25 at 1:30 PM, during an interview, the Maintenance Director stated he was responsible for maintaining resident rooms. He stated he was not aware of the flies in R #55's room. He stated the issue should have been corrected.</p>		

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<p>F 0645</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>PASARR screening for Mental disorders or Intellectual Disabilities</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on record review and staff interview, the facility failed to ensure the PASARR (Preadmission Screening and Resident Review) Level I Identification Screen accurately reflected the resident's diagnosis of major depressive disorder for 1 (R #9) of 1 (R #9) resident. If the facility does not ensure PASARR screenings are completed accurately, then residents with serious mental illness may not receive required evaluations or specialized services, placing them at risk for unmet mental health needs and a decline in psychosocial well-being. The findings are: A. Record review of the facility's Pre-admission Screening for Mental Disorder and/or Intellectual Disability Patients policy, revised 02/16/24, revealed the Social Worker or designated staff will assure all patients with mental disorders and intellectual disability received appropriate pre-admission screenings according to Federal and State regulations. The policy stated if a PASARR was not completed or was incorrect, then Social Services would coordinate with the appropriate agency to conduct the evaluation, review PASARR results to determine care needs, and incorporate recommendations into the patient's assessment and care planning. B. Record review of R #9's face sheet revealed he was admitted to the facility on [DATE] with diagnoses of liver disease, dementia, and major depressive disorder. C. Record review of R #9's Minimum Data Set (MDS; a federally mandated comprehensive assessment completed by facility staff), dated 08/26/25, revealed the following:- The resident had little interest or pleasure in doing things, felt down or depressed, had poor appetite, low energy, trouble concentrating, changes.- The resident had impaired memory recall and impaired decision-making.- A Brief Interview for Mental Status (BIMS; a screening for cognitive impairment) score 11, moderate impairment.-Psychiatric/Mood Disorder revealed depression (a mood disorder that causes a persistent feeling of sadness and loss of interest). D. Record review of R #9's PASRR Level I Identification Screening, dated 09/16/25, revealed staff documented the resident did not have a diagnosis of or a suspected mental illness. E. On 09/18/25 at 2:25 p.m., during an interview, the Social Services Director stated R #9's PASARR Level I Identification Screen was incorrect. She stated staff should have documented the resident had a diagnosis of a mental illness, because the resident had a diagnosis of major depressive disorder.</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure services provided by the nursing facility meet professional standards of quality.</p> <p>(continued on next page)</p>

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on record review and interview the facility failed to send a resident out to the hospital in a timely manner after the resident had a fall with pain and possible injury for 1 (R #97) of 1 (R #97) resident. This deficient practice could likely cause the resident to be in pain longer than necessary. The findings are: A. Record review of R #97's face sheet revealed she was admitted 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), -Osteoarthritis (condition caused by wear and tear of the joints causing loss of range of motion and pain with movement),-Chronic pain,-Left femur (long bone that connects the hip to the knee) fracture. B. Record review of R #97's After-Hour Encounter note (a note written by the provider not during regular business hours) revealed the following:- Dated 06/10/25 at 9:00 am, R #97 had a fall sometime between 06/10/25 at 9:00 pm and 06/11/25 at 1:00 am. - Dated 06/11/25 at 1:00 am, R #97 had a fall with complaint of pain to the left shoulder and the left side groin area. Plan: X-ray on the left shoulder and left hip and pelvis. C. Record review of R #97's pain documentation revealed the following:- Dated 06/10/25 at 7:31 pm was a 2 (scale 1-10, 1 was the least amount of pain and 10 was the most amount of pain).- Dated 06/10/25 at 11:28 pm was a 2. - Dated 06/11/25 at 7:15 am, was a 5. D. Record review of R #97's nursing progress notes, dated 06/11/25 at 7:48 am, indicated R #97 was transferred to the hospital due to an abnormal x-ray. E. Record review R #97's physician orders revealed the following:- Dated 06/11/25 at 8:54 am, x-ray of the left shoulder minimum of two views, one time only for pain. This order indicated it was waiting to be sent.-Dated 06/11/25 at 8:54 am, x-ray of the left hip with or without pelvis 2 to 3 views. This order indicated that it was waiting to be sent. F. Record review of R #97's nursing progress note, dated 06/11/25 at 3:15 pm, revealed R #97 pain level was noted to be a 7 out of 10. G. Record review of R #97's X-rays Report revealed the following:- Completed on 06/11/25 at 6:21 pm and read on 06/11/25 6:36 pm, x-ray to the left shoulder did not show an acute fracture or dislocation.- Completed on 06/11/25 at 6:22 pm and read on 06/11/25 at 6:36 pm, x-ray to the left hip showed a fracture to the left femoral neck (connects femoral head to the femoral shaft) with displacement of the distal fragment (portion of fractured bone that is farthest from center of the body). H. Record review of R #97's progress note, dated 06/11/25 at 7:48 pm, revealed R #97 was sent out to the hospital for hip fracture. I. On 09/18/25 at 9:57 am, during an interview, Unit Manager (UM) #2 stated staff entered the R #97's fall into the system at 7:15 am on 06/11/25. The UM #2 stated she was not clear why it took so long for R #97 to go out to the hospital. UM #2 stated she did not remember being notified of this fall for R #97. The UM #2 said sometimes non-emergent ambulance can take a while, but she never saw it take up to 12 hours to pick up a resident. J. On 09/18/25 at 10:42 am, during an interview, the Licensed Practical Nurse (LPN) #5 stated she remembered R #97 fell, but she was not working on the hall on 06/11/25 during the day shift. She stated she recalled being upset about how the nurse handled R #97's care after the fall. LPN #5 stated she went down over the 100 hall for something and saw R #97 slumped over in her wheelchair and leaning to one side. She stated R #97 complained and told her that her left side hurt. LPN #5 stated she could tell R #97 was in pain. LPN #5 stated she asked the nurse working the 100 hall to assist her with putting R #97 to bed. She stated they assisted R #97 into bed, and R #97 immediately rolled to her right side, saying it hurt, to indicate her left side hurt. LPN #5 stated R #97's nurse told the resident that she was fine. LPN #5 stated she told R #97's nurse R #97 was not fine, and she needed to call the provider. LPN #5 stated she did not know when R #97's nurse called the provider, but it was already a delay in getting R #97 treatment. LPN #5 stated she was very upset about the care for R #97, because you could tell something was wrong with R #97's hip. She stated the resident's hip did not look right. LPN #5 stated she did not know when R #97 fell, because she was not her nurse. K. On 09/18/25 at 11:43 am, during an interview, the Director of Nursing (DON) stated she did not recall being notified of R #97's fall. The DON stated sometimes it took a while for x-ray technicians to come out to do an x-ray. She stated if the resident fell after-hours, then the nurse would likely enter the orders instead of the provider. The DON stated the timeframe of the fall, getting the x-rays, and R #97 being sent out should have been faster, especially if R #97 was in pain.</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>Based on observations, interviews, and record reviews, the facility failed to ensure a residents specialized air mattress was properly inflated for 1 (R #12) of 1 (R #12) resident. If the facility fails to ensure the residents' air mattress was properly inflated, then the resident could be at risk of entrapment or of development or worsening of a resident's pressure ulcers. The findings are: A. Record review of R #12's admission Record, dated 09/16/25, revealed an admission date of 05/02/22 with the following diagnoses: -Reduced mobility (decreased ability to move the body independently). -Legally blind. -Type 2 diabetes mellitus (DM2; a disease in which the body cannot make or properly use insulin). -Morbid obesity (severely overweight). B. Record review of R #12's Provider Orders, dated 07/22/25, revealed the following: -Specialty mattress. (a mattress designed to prevent or treat pressure injuries (bedsores) by reducing or redistributing pressure on the skin) -Alternating air mattress (a therapeutic or specialty mattress that contains air cells which automatically inflate and deflate in a programmed cycle to regularly shift pressure from one area of the body to other) to the resident's bed. C. Record review of R #12's Care Plan, dated 07/23/25, revealed the resident had an alternating air mattress (a therapeutic or specialty mattress that contains air cells which automatically inflate and deflate in a programmed cycle to regularly shift pressure from one area of the body to other). D. On 09/17/25 at 9:10 AM, during an observation, the resident slept in her bed. The alternating air mattress was off, deflated, and did not have any power lights. E. On 09/17/25, at 9:18 AM, during an interview, the Licensed Practical Nurse (LPN) #1 stated R #12's air mattress was deflated. LPN #1 stated the deflated mattress could cause entrapment or additional pressure wounds for the residents. LPN #1 stated all nursing staff were responsible to check resident care equipment. F. On 09/19/25 at 2:17 PM, during an interview, the Director of Nursing (DON) stated it was her expectation for nursing staff to check resident care equipment during their daily rounds. The DON said if resident care equipment did not function properly, then it could lead to a negative outcome for the resident. She stated a deflated mattress could become an entrapment hazard if the resident was asleep in bed.</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, interview, and record review, the facility failed to properly maintain respiratory care equipment for 1 (R #6) of 1 (R #6) residents when staff failed to date R #6's oxygen humidifier (to moisturize dry oxygen). If staff fail to date oxygen humidifiers, then residents could be at risk of serious infections. The findings are:A. Record review of the facility's Oxygen Policy, last revised on 08/07/23, showed the following:- If oxygen humidifier was used, staff should label with date.- Staff should replace disposable oxygen setup (equipment used for oxygen administration) every seven days. B. Record review of R #6's Face Sheet showed the resident was admitted to the facility on [DATE] with diagnosis of congestive heart failure (CHF; impaired heart function) and anemia (low red blood cell count). C. Record review of R #6's Provider Orders showed the following:- Dated 07/28/25, an active order to administer oxygen at two liter/minute through a nasal cannula to keep oxygen above 90 percent (%), when the resident lay down. as needed for hypoxia (insufficient oxygen in the body's tissues).- Dated 09/11/25, an active order to change oxygen components and label them with date and initials as needed and every Monday for Infection Control. D. On 09/16/25 at 9:35 am, during an observation, R #6 's oxygen humidifier bottle was attached to his oxygen concentrator (oxygen supply machine) and undated. E. On 09/16/25 at 10:00 am, during an interview, Nurse #1 stated she was not aware R #6's oxygen humidifier was undated. She stated she should have dated the resident's oxygen humidifier and replaced it as needed, and every week as ordered. F. On 09/16/25 at 12:28 PM, during an interview, the Director of Nursing (DON) stated staff changed oxygen humidifiers and oxygen tubing as needed and every week. She stated undated oxygen humidifiers could put residents at risk of infection.</p>		

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NAME OF PROVIDER OR SUPPLIER  Belen Meadows Healthcare and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE  1831 Camino Del Llano Belen, NM 87002	
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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Cross reference to F759. Based on record review, observation, and interview, the facility failed to ensure pharmaceutical services (the direct, responsible provision of medication-related care) were met when staff failed to dispose of medication after it was completed for 1 (R #55) of 1 (R #55) resident. If staff fail to dispose of completed medications, then residents could be at increased risk of medication errors, receive unnecessary treatments, and medication could be diverted. The findings are:A. Record review of the facility's Disposal of Medications Policy, dated January 2024, showed the following:- If a prescriber discontinued a medication, the medication container was removed from the medication cart as soon as practicable according to State and Federal regulations in a timely manner.- Medications awaiting disposal or return were stored in a locked secure area designated for that purpose and separated from active orders until destroyed or picked up by the pharmacy staff.- Medications awaiting destruction that cannot be disposed of immediately should be recorded on a log to include the name of the individual storing the medication, resident name, the prescription number is applicable, the quantity of the medication, the strength of the medication, and the date of disposition. B. Record review of R #55's Face Sheet showed R #55 was admitted to the facility on [DATE]. C. Record review of R #55's Provider Orders, dated 08/19/25, showed an order for Artificial Tears. Instill one drop Artificial Tears ophthalmic solution in both eyes every two hours, as needed, for itchiness/dryness for seven days. The order had an end date of 08/26/25. D. Record review of the facility's Medication Disposal Form, dated 08/27/25, revealed staff did not document R #55's completed artificial tears eye drops (used to relieve dry eyes and provide temporary lubrication). E. On 10/18/25 at 10:19 am, observation of the 100-hall medication cart showed an opened and used artificial tears eye drops bottle. Certified Medication Aide (CMA) #1 stated the eye drops belonged to R #55. He stated he should have disposed of the bottle, because R #55's order was completed on 08/26/25. F. On 09/18/25 at 11:00 am, during an interview, Nurse #2 stated he received completed and discontinued medications from nurses and CMAs, and he destroyed them. Nurse #2 stated he prepared a monthly report of destroyed medications in a Medication Disposal Form. Nurse #2 stated he did not receive R #55's completed eye drops. G. On 09/18/25 at 11:20 am during an interview, the Director of Nursing (DON) stated she expected Licensed Nurses and CMAs to dispose of completed medications and not to keep the completed medications in medication carts.</p>		

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<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure medication error rates are not 5 percent or greater.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Cross reference to F755 Based on observations, record reviews, and interviews, the facility failed to ensure the medication error rate did not exceed 5 percent (%) for 2 (R #55 and R #73) of 2 (R #55, and R #73) residents. Staff administered 26 medications with three errors resulting in a medication error rate of 8.6%. If staff administer medications in error, then residents are likely to experience less than optimal results from their medication regimen (a prescribed systematic form of treatment for a course of drugs). The findings are:</p> <p>R #73</p> <p>A. Record review of the facility's Medication Administration Policy, dated [DATE], showed the following:</p> <ul style="list-style-type: none"> <li>- Medications were administered in accordance with written orders of the prescriber.</li> <li>- Medications to be given on an empty stomach or before meals were to be scheduled for administration thirty minutes to two hours prior to meals.</li> <li>- Medications were administered within sixty minutes of scheduled time unless otherwise specified by the prescriber.</li> </ul> <p>B. Record review of R #73's Face Sheet showed R #73 was admitted to the facility on [DATE] with diagnoses of history of venous thrombosis and embolism (blood clot) and hypothyroidism (the thyroid is not making enough thyroid hormone).</p> <p>C. Record review of R #73's Provider Orders showed the following:</p> <ul style="list-style-type: none"> <li>- Dated [DATE], an active order to administer levothyroxine (a medication prescribed to manage hypothyroidism) oral tablet 75 microgram (mcg). Give one tablet by mouth one time a day, 30 to 60 minutes before breakfast, for hypothyroidism.</li> <li>- Dated [DATE], an active order to administer apixaban (blood thinner) oral tablet 5 milligrams (mg). Give one tablet by mouth two times a day at 8:00 am and 8:00 pm for blood clots.</li> </ul> <p>D. On [DATE] at 9:24 am, during observation, Certified Medication Aide (CMA) #1 prepared, poured, and administered the levothyroxine and apixaban to R #73.</p> <p>E. On [DATE] at 9:26 am during an interview, CMA #1 stated he should have administered the levothyroxine 30 to 60 minutes before breakfast and administered the apixaban within a two-hour period, one hour before to one hour after the scheduled time specified by the provider. He stated he was assigned to two resident halls, and that made him administer R #73's medications late. CMA #1 stated R #73 ate her breakfast before she received her morning medications.</p> <p>(continued on next page)</p>		

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<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>F. On [DATE] at 10:28 am during an interview, the Director of Nursing (DON) stated she expected CMA #1 to administered R #73's medications at the scheduled times as ordered by the prescribing provider. The DON stated the facility had a medication administration policy to administer medications within one hour before to one hour after the scheduled time, unless otherwise specified by the provider.</p> <p>R #55</p> <p>G. Record review of the facility's Non-controlled Medications Orders Policy, last revised [DATE], revealed medications were administered only upon the receipt of a clear, complete, and signed order by a person lawfully authorized to prescribe.</p> <p>H. Record review of the facility's Medication Administration Policy, dated [DATE], revealed staff should review and confirm medication orders for each individual resident on the Medication Administration Record prior to administration.</p> <p>I. Record review of R #55's Face Sheet showed R #55 was admitted to the facility on [DATE].</p> <p>J. Record review of R #55's Provider Orders, dated [DATE], showed an order for Artificial Tears. Instill one drop of Artificial Tears Ophthalmic Solution in both eyes every two hours, as needed, for itchiness/dryness for seven days. The order had an end date of [DATE].</p> <p>K. On [DATE] at 9:14 am, during an observation, R #55 had visible redness around eyes and irritation, as evidenced by R #55 rubbing her eyes.</p> <p>L. On [DATE] at 9:15 am, CMA #2 administered Artificial Tears to R #55.</p> <p>M. On [DATE] at 9:01 am, during interview, R #55 stated she could request Artificial Tears from nurses whenever she needed them. R #55 stated she last requested and received Artificial Tears on [DATE].</p> <p>N. On [DATE] at 11:40 am, during an interview, the DON stated the CMAs completed weekly medical cart audits. The DON stated CMAs go through medications in medical carts and take out any medications that are expired or discontinued. The DON stated medications should not be given to a resident without an active order. The DON stated it was the responsibility of the CMAs completing cart audits and whoever was administering medications at the time to make sure orders were active and up to date. The DON stated it was her expectation nurses and CMAs would not give any medications to residents without an active order.</p> <p>O. On [DATE] at 12:15 pm, during a phone interview, CMA #2 stated she administered Artificial Tears to R #55 on [DATE]. CMA #2 stated she thought R #55 had an active order for Artificial Tears. CMA #2 stated all medications must have an order prior to administering to the resident. CMA #2 stated it was primarily the responsibility of the doctor to make sure orders were up to date. CMA #2 stated potential hazards of administering medications without active order could result in a resident having an allergic reaction or interaction with other medications.</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p>Based on observation and interview, the facility failed to protect a treatment cart (a movable piece of equipment used in healthcare facilities to store, transport, and dispense treatment supplies and tools) from unauthorized access when staff failed to lock the treatment cart while staff were away from the cart. This deficient practice had the potential to affect all residents on the 200 Unit. If staff fails to lock an unsupervised treatment cart, then residents could obtain medical equipment which could result in injury or death. The findings are: A. On 09/18/25 at 9:01 AM, during an observation of the 200 Unit, the treatment cart top drawer was opened, and the contents were exposed. Staff were not present in the area near the treatment cart. Further observations revealed the treatment cart had wound care dressing, wound cleanser, tweezers, barrier cream, irrigation solution, and scissors. B. On 09/19/25 at 9:10 AM, during an interview, Registered Nurse (RN)#1 stated he was responsible for the unlocked and opened treatment cart. RN #1 stated he stepped away to assist a resident and left the top drawer of the cart open, which exposed the contents of the treatment cart. He stated it was his expectation to lock the treatment cart when it was unattended. RN #1 stated if a resident had accessed the open treatment cart, the resident could have ingested something. C. On 09/19/25 at 2:15 PM, during an interview, the Director of Nursing (DON) stated staff were never to leave a treatment cart open and unattended. The DON stated it was her expectation for staff to lock all treatment and medication carts when staff were not attending them. She stated if a treatment cart was unlocked, then residents could ingest an item.</p>		

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<p>F 0790</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide routine and 24-hour emergency dental care for each resident.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on record reviews and interviews, the facility failed to ensure residents obtained routine dental care for 1 (R #6) of 1 (R #6) resident reviewed for dental services, when the facility failed to provide documentation to show R #6 received routine dental services at least annually. If staff fail to arrange for residents' dental services, then it could lead to untreated tooth decay (damage to tooth surface), gum disease, and other oral health issues like bad breath, tooth sensitivity, and tooth loss. The findings are:A. Record review of the facility's Dental Services policy, dated 11/28/17 and last revised on 09/15/25, showed the following:- The facility provided or obtained, from an outside resource, routine and emergency dental services, to meet the needs of each resident.- Routine dental services meant an annual inspection of the oral cavity for signs of disease, diagnosis of dental disease, dental x-rays as needed, dental cleaning, and fillings (a treatment to repair a damaged tooth).- When necessary or if requested, the facility assisted residents in making dental appointments and arranged transportation to and from the dental service location.- The policy did not state staff roles in arranging those appointments. B. Record review of R #6's Face Sheet showed the resident was admitted into the facility on [DATE]. C. Record review of R #6's Provider Orders, dated 07/15/24, showed an order to send R #6 for a dental appointment on 7/22/24 at 10:30 am. Transportation staff to provide transportation. The provider discontinued the order on 09/17/24. D. Record review of R #6's Electronic Health Record (EHR), undated, showed staff did not document R #6 saw a dentist after the 07/15/24 provider order. Further review revealed R #6 last saw a dentist on 11/21/22. E. On 19/16/25 at 9:31 am, during observation and interview, R #6 stated she did not have any dental services in a while. She stated she had pain in several teeth and pointed at her mouth. R #6 stated she had her natural teeth. F. On 09/16/25 at 1:40 pm during an interview, the Social Services Director (SSD) stated the facility sent R #6 to her dental appointment on 11/21/22. She stated the facility's driver kept track of residents' routine dental appointments. She stated she occasionally helped the driver and let him know when new residents needed dental appointments. SSD stated she was not aware R #6 did not go to dental appointments annually. G. On 09/16/25 at 2:15 pm, during an interview, Nurse Manager #1 stated the facility's driver kept track of residents' routine dental appointments. She stated she occasionally let the driver know when she wanted him to schedule new dental appointments. Nurse Manager #1 stated she was not aware R #6 did not go to dental appointments annually. H. On 09/19/25 at 9:47 am, during an interview, the facility driver stated he kept track of residents' routine dental appointments and their due dates. He stated social services staff and nurse managers alerted him when they needed him to schedule new dental appointments. The driver stated he was responsible for keeping track of and scheduling routine dental appointments. The driver stated he was responsible for driving residents to their appointments when they were due. I. On 09/19/25 at 11:47 am during an interview, the Director of Nursing (DON) stated the facility's driver was not supposed to be solely responsible for arranging residents' dental appointments. She stated the Interdisciplinary Team (IDT; includes but is not limited to the attending physician, a registered nurse with responsibility for the resident, a nurse aide with responsibility for the resident, a member of the food and nutrition services staff, resident or resident representative, and other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident) was supposed to collaborate in arranging those appointments.</p>		

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<p>F 0806</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options.</p> <p>Based on record reviews, observation, and interviews, the facility failed to honor a resident's dietary preference for 1 (R #12) of 1 (R #12) resident. If the facility failed to serve a resident a vegetarian diet, then resident might receive meat and feel unheard and unimportant. The findings are: A. Record review of R #12's admission Record, dated 09/16/25, revealed an admission date of 05/02/2022 with the following diagnoses:-Type II diabetes mellitus. (DM; a disease in which the body cannot make or properly use insulin). -Morbid obesity. (severely overweight).-Legally blind (a significant and permanent loss of vision). B. Record review of R #12's admission Diet Order, dated 05/22/22, revealed regular diet, vegetarian, no eat eggs, and no meat. C. Record review of R #12's Care Plan, dated 09/02/25, revealed the following:- Consistent carbohydrate diet (a consistent amount of carbohydrates to help manage blood glucose levels).- The care plan did not address a vegetarian diet, no meat, and no eggs. D. Record review of R #12's Minimum Data Set (MDS; a federally mandated assessment instrument completed by facility staff), dated 09/08/25, revealed a diabetic diet (a meal plan that helps manage blood sugar levels). E. On 09/15/25 at 11:26 AM, during an interview, R #12 stated she was a vegetarian but received meat with every meal. R #12 stated the facility did not provide her with an alternative meal. She stated she was hungry, because she could only eat the salad. F. On 09/18/25 at 1:30 PM, during an observation and interview, R #12's lunch consisted of a pork sandwich and coleslaw. R #12 stated she received salad and meat, which she believed was pork. She stated she did not eat the meat, and she needed a snack. R #12 stated she consistently reminded staff of her dietary preference but continued to receive meals with meat. G. Record review of R #12's lunch ticket, dated 09/18/25, revealed a regular diet, and staff were to serve the resident a pork sandwich for lunch. H. On 09/19/25 at 1:43 PM, during an interview, the Dietary Director stated R #12 had several diet orders in the system: a regular diet, a CCHO diet, and a vegetarian diet. He stated the residents were currently on a regular liberalized diet (a modified therapeutic diet in which previous dietary restrictions are reduced or removed to promote better intake and quality of life). The Dietary Manager stated R #12's lunch ticket was incorrect, and R #12 should be on a CCHO and vegetarian diet. The Dietary Director stated his expectation was for staff to serve all residents the correct diet to avoid an adverse reaction. I. On 09/19/25 at 2:26 PM, during an interview, the Director of Nursing (DON) stated she was not aware R #12 received the incorrect diet. The DON stated it was her expectation for all residents to receive the correct diet. She stated if a resident received the incorrect diet, then it could lead to an allergic reaction or sickness.</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>Based on observation and interview, the facility failed to ensure the filters on the ice machine were replaced timely. This failure had the potential to affect all residents at the facility. This deficient practice could likely cause pollutants to enter the water causing contamination and illness. The findings are: A. On 09/16/25 at 9:29 am, an observation revealed the filters of the ice machine had a replacement date of 04/24/25. There were two filters, and they had the same change by date. The instructions on the filters recommended changing the filters at least once per year. B. On 09/16/25 at 9:31 am, during an interview, the District Manager stated the Maintenance Director was responsible for changing and ordering the filters. C. On 09/19/25 at 11:45 am, an observation revealed the ice machine had the same filters with a replacement date of 04/24/25. D. On 09/19/25 at 11:56 am, during an interview, Maintenance Director stated the filters needed to be changed.</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p>Based on record review and interview, the facility failed to keep accurate and complete resident records for 2 (R #97 and #123) of 2 (R #97 and #123) residents. This deficient practice could likely cause confusion about the resident's care the resident based on the documentation presented in the resident's electronic medical record. The findings are: R #97 A. Record review of R #97's face sheet revealed an admission date of 04/19/24 with the following diagnoses:- Dementia (a group of conditions characterized by impairment of at least two brain functions, such as memory loss and judgment),-Osteoarthritis (condition caused by wear and tear of the joints causing loss of range of motion and pain with movement),-Chronic pain,-Left femur (long bone that connects the hip to the knee) fracture. B. Record review of R #97's After-Hour Encounter note (a note written by the provider not during regular business hours) revealed the following:- Dated 06/10/25 at 9:00 am, R #97 had a fall sometime between 06/10/25 at 9:00 pm and 06/11/25 at 1:00 am. - Dated 06/11/25 at 1:00 am, R #97 had a fall with complaint of pain to the left shoulder and the left side groin area. Plan: X-ray on the left shoulder and left hip and pelvis. C. Record review of the facility's documentation of after-hours provider notification regarding R #97's fall, and provided by the Corporate Nurse, revealed the following:-After Hours Encounter Note in R #97's electronic medical record documented a call occurred on 06/10/25 at 9:00 pm, but the facility's after-hours provider notification documentation stated the call occurred on 06/11/25 at 7:20 am.- After Hours Encounter Note in R #97's electronic medical record documented a call occurred on 06/11/25 at 1:00 am, but the facility's after-hours provider notification documentation stated the call occurred on 06/11/25 at 7:26 am. D. On 09/19/25 at 2:30 pm, during an interview, the Corporate Nurse stated he was not sure why the times on R #97's After-Hour Encounter notes in the electronic medical record were different than the list of times he pulled from the provider record. The Corporate Nurse stated there was a problem, but he was not clear on why the documentation was not accurate. R #123E. Record review of R #123's face sheet indicated an admission date of 08/12/25 with the following diagnoses:- Quadriplegia (paralysis of all four limbs),-Chronic pain,-Anxiety (feelings of fear or apprehension),-Depression (a mood disorder that causes a persistent feeling of sadness and loss of interest). F. Record review of R #123's Activities of Daily Living (ADL; activities related to personal care such as bathing, dressing, hygiene, toileting, and eating) flow sheet (a document on which Certified Nursing Assistants document care), dated 08/12/25 to 08/23/25, indicated the record did not have documentation for the following areas:-Bathing, 2 out of 4 entries were missing.-Bed mobility, 30 out of 35 entries were missing.-Dressing, 30 out of 35 entries were missing.-Hygiene, 30 out of 35 entries were missing.-Toileting, 30 out of 35 entries were missing.-Eating, 21 out of 31 entries were missing. G. On 09/19/25 at 2:57 pm, during an interview, the Director of Nursing (DON) stated the documentation for R #123 was not acceptable. She stated sometimes agency staff did not have access to the electronic medical record to document the care they provided to the residents. She stated R #123 was not at the facility very long, and that might be why management did not notice the lack of documentation.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Provide and implement an infection prevention and control program.</p> <p>Based on observations, record reviews and interviews, the facility failed to:-Follow proper infection control practices for handling laundry when staff failed to ensure- laundry was free from used sharps. If staff fail to handle used laundry, then residents could be at risk of development and transmission of disease and infections.- 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 LWMP. This deficient practice is likely to lead to outbreaks 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: Sharps in the Laundry</p> <p>A. Record review of the facility's Needle Handling and Sharps Injury Prevention policy, last revised on 04/15/23, showed shaving razors must be placed in sharps disposal containers (a rigid, puncture-proof plastic container designed to safely hold used needles, syringes, and other sharp medical objects). The policy did not mention the possibility of contaminating linen with sharps or how to prevent such incidents.</p> <p>B. On 09/19/25 at 1:12 pm, during an observation and interview, a sharps disposal container located in the laundry room contained multiple shaving razors. Laundry Technician #1 stated the shaving razors were in the sharps container, because she found razors in dirty residents' towels when staff brought towels in the laundry room. She stated she reported the incidents but did not recall when or to whom she reported the incidents.</p> <p>C. On 09/19/25 at 1:20 pm, during an interview, the facility's Infection Control Preventionist stated she was not aware laundry staff found razors in dirty linen. She stated staff did not report the incidents to her. The ICP stated leaving used shaving razors in towels could put laundry staff at risk of blood-borne pathogens (germs live in blood).</p> <p>D. On 09/19/25 at 1:50 pm, during an observation and interview, sharps disposal containers were mounted in the shower rooms in 100, 200, 300, and 400 halls. Certified Nurse Aide (CNA) #1 stated staff should dispose of used razors in sharps disposal containers located in the shower rooms.</p> <p>E. On 09/16/25 at 3:21 pm, during an interview, the Director of Nursing (DON) stated she was not aware laundry staff found used razors in dirty towels. The DON stated staff did not report the incidents to her. She stated staff should discard used razors in the sharp disposal containers located in shower rooms. The DON stated such incidents put laundry staff at risk of infections.</p> <p>Water Management Plan</p> <p>F. Record review of the facility's WMP, last revised on 09/13/25, showed the following:</p> <ul style="list-style-type: none"> <li>- 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.</li> </ul> <p>(continued on next page)</p>		

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  11/18/2025
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)
<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<ul style="list-style-type: none"> <li>- 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.</li> <li>- 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.</li> <li>- 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.</li> </ul> <p>G. On 09/19/25 at 10:00 am, during an interview with the facility's Administrator, Director of Nursing, Maintenance Director, and the Infection Control Preventionist, they stated the WMP team reviewed the WMP yearly, and the last time they reviewed the plan was on 09/13/25. They stated they were not aware the WMP 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.</p>

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  11/18/2025
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0908</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Keep all essential equipment working safely.</p> <p>Based on observation, interview, and record review, the facility failed to ensure a resident's wheelchair was maintained in safe operating condition for 1 (R #62) of 1 (R #62) resident. If staff do not maintain resident equipment, then residents are at risk of injury. The findings are: A. Record review of R #62's Minimum Data Set (MDS; a federally mandated assessment instrument completed by facility staff), dated 07/03/25, identified diagnoses of repeated falls, generalized muscle weakness, and need for assistance with personal care. B. Record review of R # 62's comprehensive care plan, revised on 09/12/25, showed interventions for assistance with activities of daily living (ADL; personal care tasks such as bathing, dressing, eating, toileting, and mobility), transfers, locomotion, and mobility due to limited mobility. C. On 09/16/25 at 12:29 a.m., during an observation and interview, R # 62 sat in his wheelchair in the common area. The back bar across the wheelchair was not attached and hung on the left side. R # 62 stated his wheelchair was broken for an extended period of time. D. On 09/19/25 at 10:01 a.m., during an interview, Licensed Practical Nurse (LPN) stated she noticed R # 62's wheelchair was broken. She stated she told the night nurse to notify the therapy staff, but she did not document the broken wheelchair in the resident's progress notes. E. On 09/26/25 at 12:12 p.m., during an interview, the Physical Therapist (PT) stated her expectation was for staff to submit a workorder in TELS (a computerized maintenance reporting system) for R #62's wheelchair to get the back of the wheelchair fixed. She stated the wheelchair was unsafe for the resident. She stated R #62's wheelchair was missing the back bar that went across the back of the chair, and they could not find the knob that secured the bar. She stated her expectation was for staff to place the resident into a different wheelchair until staff completed the repairs to his wheelchair.</p>