STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	325070	A. Building B. Wing	06/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Red Rocks Care Center	3720 Church Rock Road Gallup, NM 87301

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. Based on record review and interview, the facility failed to complete and submit a Five Day Report (a report sent to the State Survey Agency which includes the results of the facility's investigation into alleged violations) to the State Agency regarding allegations of neglect (the failure of the facility, its employees, or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress) for 1 (R #5) of 1 (R #5) residents. If the facility does not submit follow-up reports, then the State Agency cannot assure the residents are safe and free of neglect. The findings are: A. Record review of the facility's Reportable Incidents and Conditions policy, dated 06/01/15, revealed the following: - Staff will report, review, and investigate all reportable incidents and conditions which occurred, or allegedly occurred, on the property and involved, or allegedly involved, a resident who received services. - The Executive Director, Resident Care Director, or designee will review all reportable incidents and conditions to determine if: -Required documentation has been completed; and -Interventions to prevent further incident have been identified and implemented. - When conduction and investigation, the Executive Director, Resident Care Director, or designee will: - Monitor that all aspects of the reportable incident or condition and investigation are documented; - Complete the investigation within five working days. - The progress and outcome of investigation is communicated to appropriate leadership and to State Agencies, as indicated. B. Record review of R #5's face sheet revealed an initial admission date of 07/21/22 with the following diagnoses: (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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Dementia (a group of conditions characterized by impairment of at least two brain functions, such as memory loss and judgment), - Dysphagia (difficulty or discomfort in swallowing). C. Record review of the facility's Facility Reported Incident, dated 05/05/25, revealed R #5 sat across from the nursing station after activities concluded. A nurse noticed R #5 was unable to speak and had a flushed face and watery eyes. The nurse went to assist the resident and observed the crumbs of a sandwich on the floor around the chair of R #5. D. Record review of the facility's records revealed the records did not contain documentation to show the facility submitted a Five Day Follow-Up Report to the State Survey Agency. E. On 06/13/25 at 1:34 pm during an interview, the Director of Nursing (DON) stated staff were to investigate and start initial reporting for all reportable incidents within two hours and to complete the investigation in five days. She stated she expected for staff to complete the investigations of reportable incidents by the fifth day, to include the completion of the Five Day Follow-Up Report. The DON stated staff completed the investigation for R #5 within five days, but the facility failed to submit the Five Day Follow-Up Report to the State Survey Agency.

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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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. Based on record review and staff interview, the facility failed to provide a copy of the planned Involuntary Discharge Notice to the State Long-Term Care Ombudsman for 2 (R #3 and #4) of 3 (R #3, #4 and #7) residents. This deficient practice could result in residents being discharged without necessary advocacy or support from the Ombudsman's office. The findings are: R #3 A. Record review of R #3's Notice of Involuntary Discharge, dated 03/06/25, revealed the facility sent the resident's Involuntary Discharge Notice to the State Long-Term Care Ombudsman in another state. The facility did not send the discharge notice to the New Mexico Long-Term Care Ombudsman. B. On 06/12/25 at 10:31 am during an interview, the New Mexico Long-Term Care Ombudsman stated she did not receive R #3's Notice of Involuntary Discharge, dated 03/06/25. C. On 06/12/25 at 12:46 pm during an interview, the Social Services Director (SSD) stated she sent R #3's Notice of Involuntary Discharge, dated 03/06/25, to the Long-Term Care State Ombudsman in the wrong state. R #4 D. Record review of R #4's Notice of Involuntary Discharge, dated 03/05/25, revealed the facility sent the resident's Involuntary Discharge Notice to the State Long-Term Care Ombudsman in another state. The facility did not send the discharge notice tot he New Mexico Long-Term Care State Ombudsman. E. On 06/12/25 at 10:31 am during an interview, the New Mexico Long-Term Care Ombudsman stated she did not receive R #4's Notice of Involuntary Discharge, dated 03/05/25. She stated she had concerns residents did not receive the correct information to receive advocacy services should they appeal the discharge. F. On 06/12/25 at 12:46 pm during an interview, the Social Services Director (SSD) stated she sent R #4's Notice of Involuntary Discharge, dated 03/05/25, to the Long-Term Care State Ombudsman in the wrong state. She stated she was not aware she sent the notice to the wrong entity. She stated she followed the instructions she received from the Corporate SSD,who advised her to use a template which included the contact information for an Ombudsman in a different state.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on observation and interview, the facility failed to safeguard residents' personal health information when the facility mailed a notice of involuntary discharge to an unauthorized entity for 2 (R #3 and #4) of 3 (R #3, #4 and #7) residents. If the facility fails to ensure the confidentiality, security, and proper management of resident records, then residents are at risk of unauthorized persons accessing their personal and medical information. The findings are: A. Record review of R #3's Notice of Involuntary Discharge, dated 03/06/25, revealed the facility sent the resident's notice to the State Long-Term Care Ombudsman in another state. The facility did not send the discharge notice to the State Long-Term Care Ombudsman in New Mexico. B. Record review of R #4's Notice of Involuntary Discharge, dated 03/05/25, revealed the facility sent the resident's notice to the State Long-Term Care Ombudsman in another state. The facility did not send the discharge notice to the State Long-Term Care Ombudsman in New Mexico. C. On 06/12/25 at 10:31 am during an interview, the New Mexico State Ombudsman (SO) stated she was made aware the facility sent R #3's and R #4's discharge information to the wrong state ombudsman when the ombudsman from the other state reached out to her. She stated the ombudsman from the other state reported they received two New Mexico Notices of Involuntary Discharge. The SO stated she reached out to the facility Administrator, because she had concerns with resident information being shared with unauthorized persons. She stated there was not a resolution to ensure discharge notices would be sent to the correct state ombudsman. The SO stated she was concerned residents might not realize they could appeal the involuntary discharge, and the resident would not have the correct contact information for the SO who could assist residents in the process. D. On 06/12/25 at 12:46 PM during an interview, the Social Services Director (SD) stated she sent R #3's and R #4's Notice of Involuntary Discharge to the State Ombudsman in another state. She stated her Corporate Social Services Director (CSSD) provided her with a template for the notice that included ombudsman contact information, and the CSSD advised her to use the template. She stated she was not aware she sent the Notice of Involuntary Discharge to the incorrect state ombudsman.