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	12/05/2025

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

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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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure a resident or their representative were aware of a medication taken by the resident, which included the risks and benefits associated with that medication for 1 (R #14) of 1 (R #14) resident reviewed for unnecessary medications. If residents and/or their representative is not informed of the risks and benefits of each medication, then they are likely not able to make informed decisions. The findings are:? A. Record review of the facility's Behaviors: Management of Symptoms policy, last revised on 09/15/25, revealed residents exhibiting behavioral symptoms will be individually evaluated to determine the behavior. Further review revealed when medication is ordered for behavioral symptoms, consent (from the resident or resident representative) is to be obtained. B. Record review of R #14's Face Sheet, revealed R #14 was originally admitted to the facility on [DATE] with the diagnosis of unspecified dementia (a group of conditions characterized by impairment of at least two brain functions, such as memory loss and judgment) with agitation. C. Record review of R #14's minimum data set (MDS, which was part of the federally mandated process for clinical assessment of all residents in Medicare and Medicaid certified nursing homes) completed on 11/10/25 indicated R #14 had a brief interview for mental status (BIMS; screening for cognitive impairment) score of 0 (0-7 is severe impairment.) D. Record review of R #14's nursing progress notes revealed the following: 08/04/25: Gradual dose reduction (GDR; the stepwise tapering of a dose to determine if symptoms, conditions, or risks can be managed by a lower dose or if the medication can be discontinued altogether) meeting note stated the primary care physician (PCP) determined the GDR was contraindicated due to R #14 still exhibiting behaviors.? ? 08/04/25: Note of PCP order to start Risperdal (antipsychotic) 1 milligram (MG). E. Record review of R #14's physician orders revealed the following orders: 08/05/25: Risperdal 1MG, order was discontinued on 11/13/25.11/14/25: Risperdal 1MG for delusions and mood changes was started. Order was discontinued on 12/02/25.12/03/25: Risperdal 1MG for unspecified dementia, severe, with agitation was started. Order status was active. F. Record review of R #14's medication administration record (MAR) for September October, and November 2025 revealed Risperdal was administered to R #14 every day for all three months reviewed. G. Record review of R #14's psychotropic medication consent forms revealed the following:Consent for Quetiapine (antipsychotic) medication dated 11/20/24.Consent for Quetiapine medication dated 01/10/25.Consent for Seroquel (antipsychotic) medication dated 02/05/25.A consent form for Risperdal was not present. H. On 12/05/2025 at 10:58 am, during interview with the Director of Nursing (DON), she stated if a resident was determined to need psychotropic medication, staff had the resident complete a consent form within 24 hours.??The DON stated if a resident could not sign the consent form, staff called the resident's family to obtain verbal consent, and all nurses were responsible for obtaining consent forms. The DON confirmed R#14 did not have a consent form for the medication Risperdal and should have.

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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews and interview, the facility failed to ensure the Minimum Data Set (MDS; a federally mandated comprehensive assessment?of a resident's?functional, medical, psychosocial and cognitive assessment completed by facility staff) was accurate for 1 (R #4) of 1 (R #4) resident reviewed for MDS assessments. This deficient practice is likely to result in the facilities failure to provide adequate care and treatment of the?resident's needs. The findings are: A. Record review of R #4's face sheet revealed R #4 was admitted into the facility on [DATE] with the following diagnoses: Diagnosis of blindness, one eye,Diagnosis of acquired absence of eye (complete loss of the eyeball due to injury, disease, surgery, or other medical conditions). ?B. Record review of R #4's Quarterly MDS Section B: Hearing, Speech and Vision dated 10/27/25 was coded as the resident having adequate vision. ?C.?Record review of R #4's Care Plan, dated 10/15/25 revealed the following: Resident is at risk for falls related to blindness in one eye,Arrange residents' environment to enhance vision and maximize independence,Reposition items as needed to location within visual field,Impaired vision,Monitor conditions that may contribute to ADL (activities of daily living (ADL; activities related to personal care such as bathing, showering, dressing, walking, toileting, and eating) decline, including vison impairment. ?D. Record review of R #4's Physician Orders, dated 12/05/25 revealed the following: Referral to Ophthalmology (branch of medicine concerned with the study, diagnosis, treatment, and prevention of diseases and disorders of the eye and visual system) for loss of vision to left eye,Transfer to Emergency Department for evaluation of blindness in left eye. E. On 12/05/25, at 11:45 AM, during an interview with the?MDS Coordinator (MDSC), she stated R #4's MDS assessment dated [DATE] was inaccurate. The MDSC stated the information entered was incorrect because R #4 is legally blind and does not have adequate vison. The MDSC stated it is her expectation every MDS is completed with the residents correct medical history and diagnosis for proper treatment.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure the Preadmission Screening and Resident Review (PASRR; a federal requirement to help ensure individuals who have a mental disorder or intellectual disabilities are not inappropriately placed in nursing homes for long term care)?was accurate for 5 (R #5, R #27, R #55, R #66, and R #94) of 5 (R #5, R #27, R #55, R #66, and R #94) residents reviewed for PASRR accuracy. This deficient practice is likely to result in the facility not providing the services needed by residents who are identified in the screening process for additional care and services. The findings are: R #5 A. Record review of R #5's face sheet revealed the resident was admitted into the facility on [DATE] with the following diagnoses: Major depressive disorder (a mental health disorder characterized by persistently depressed mood or loss of interest in activities, causing significant impairment in daily life). Post-traumatic stress disorder (PTSD; a mental health condition triggered by a terrifying event, causing flashbacks, nightmares, and severe anxiety). Unspecified Dementia?(a group of conditions characterized by impairment of at least two brain functions, such as memory loss and judgement). Anxiety. ?B. Record review of R #5's PASARR Level I dated 02/19/25 revealed the section titled 1. Is there a diagnosis or suspected mental illness? did not have Yes or No selected. The form section intended to identify mental-illness-related diagnoses remained incomplete. ?C. On 12/05/25 at 11:18 AM during an interview, the admission Director (AD), she stated?R #5's diagnosis of major depressive?disorder was a mental?illness. She stated the admission department was responsible for the completion of the PASRR screening and the screening was incorrect for R #5 because Section C, question 1, was not answered.? R #27: D. Record review of R #27 Face Sheet revealed R #25 was admitted on [DATE] to the facility with the following diagnosis: Major depressive disorder.? (major depressive disorder (a mental health disorder characterized by persistently depressed mood or loss of interest in activities, causing significant impairment) E. Record review of R #27's PASRR Level 1 Screening, dated 05/19/25 revealed the following: Section C, identification of mental illness evaluation criteria, including diagnoses such as schizophrenia, or disorders of mood, panic, anxiety, personality, psychotic, somatoform, substance related. (this list is not all-inclusive; contact the PASRR office for questions on a particular diagnosis), was unanswered. (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	?F.??Record review of R #27's Base Line Care Plan dated 11/03/25 revealed R #27 uses an antidepressant for depression. ?G. Record review of R #27 Physician Orders, dated 12/05/25 revealed the following: Monitor for signs or symptoms of increased depression or possible suicidal ideation,? Medi telecare- (company that provides mental health care using telehealth) to evaluate and treat psychiatric and psychological health depression, Sertraline 100 mg (milligram) give 1 tablet by mouth, one time a day for depression.? Resident exhibits or is at risk for distressed/fluctuating mood symptoms related to sadness/depression caused by diagnosis of Major Depressive Disorder.? ?H. Record review of R #27's PHQ-2 to 9 Evaluation (PHQ-9 is a 9-question tool used to screen for depression and measure how severe the symptoms are) dated 10/17/25 revealed the resident feeling down, depressed or feeling hopeless. R #27's PHQ-2 to 9 evaluation was incomplete and without a score reported by the facility. ?I. On 12/05/25 at 11:24 AM during an interview, the admission Director (AD) stated?R #27's diagnosis of major depressive?disorder was a mental?illness. She stated the admission department was responsible for the completion of the PASRR screening and the screening was incorrect for R #27 because it lacked the resident's diagnosis of major depressive disorder.?? ?R #55:? J. Record review of R #55's face sheet revealed R #55 was admitted into the facility on [DATE] without a diagnosis or history of mental illness. K. Record review of R #55's PASRR Level 1 Screening, dated 11/11/25, revealed the following: Section C, identification of mental illness evaluation criteria, including diagnoses such as schizophrenia, or disorders of mood, panic, anxiety, personality, psychotic, somatoform, substance related. (this list is not all-inclusive; contact the PASRR office for questions on a particular diagnosis), was unanswered. L. On 12/05/25 at 11:29 AM during an interview, the admission Director (AD) she stated?R #55's diagnosis of major depressive?disorder was a mental?illness. She stated the admission department was responsible for the completion of the PASRR screening and the screening was incorrect for R #55's because Section C, question 2, was not answered. R #66:? M. Record review of R #66 Face Sheet revealed R #66 was admitted into the facility on [DATE] with the following diagnoses: Diagnosis of major depressive disorder. (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Diagnosis of anxiety disorder. N. Record review of R #66's PASRR Level 1 Screening, dated 01/23/24, revealed the following: Section C, identification of mental illness evaluation criteria, including diagnoses such as schizophrenia, or disorders of mood, panic, anxiety, personality, psychotic, somatoform, substance related. (this list is not all-inclusive; contact the PASRR office for questions on a particular diagnosis), was answered as not identified. ?O.??Record review of R #66's Base Line Care Plan, dated 07/04/24 revealed the following: Resident uses an antidepressant for depression, Resident exhibits or is at risk for distressed/fluctuating mood symptoms related to sadness/depression caused by diagnosis of Major Depressive Disorder.? ?P. Record review of R #66's Physician Order Summary Report, dated 12/05/25 revealed the following:? Monitor for signs and symptoms of increased depression, Fluoxetine (antidepressant) 20 mg tablet by mouth for depression. Q. On 12/05/25 at 11:35 AM during an interview, the admission Director (AD), she stated the admission department was responsible for the completion of the PASRR screening and the screening was correct for R #66. AD was unaware of R #66's diagnosis of major depressive disorder. R #94: R. Record review of R 94's Face Sheet revealed R #94 was admitted into the facility on [DATE] with the following diagnosis: Diagnosis of anxiety disorder. S.?Record review of R #94's PASRR Level 1 Screening, dated 03/12/24, revealed Section C, identification of mental illness evaluation criteria, including diagnoses such as schizophrenia, or disorders of mood, panic, anxiety, personality, psychotic, somatoform, substance related. (this list is not all-inclusive; contact the PASRR office for questions on a particular diagnosis), was answered as not identified. T. Record review of R #94's?Minimum Data Set (MDS; a federally mandated assessment instrument completed by facility staff)?dated 06/06/25 revealed Section I- (Active Diagnosis) was coded as anxiety disorder.? ? U. On 12/05/25 at 11:42 AM during an interview, the admission Director (AD) she stated the admission department was responsible for the completion and accuracy R #94's PASRR screening and the screening was correct. AD was unaware of R #94's diagnoses of major depressive disorder and anxiety disorder.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted Based on record review and interview, the facility failed to develop and implement an adequate baseline care plan (minimum healthcare information necessary to properly care for a resident immediately upon their admission to the facility) for 2 (R #1 and #42) of 3 (R #1, #42 and #48) residents reviewed for baseline care plans, when: R #1's baseline care plan was incomplete and inaccurate due to the baseline care plan failing to include multiple diagnoses with interventions for R #1. A baseline care plan was not developed within 48 hours of admission for R #42. If the facility fails to develop and implement an adequate baseline care plan within 48 hours of admission for residents, then staff may lack necessary guidance to provide appropriate care which could lead to an adverse event (undesirable experience, preventable or non-preventable, that causes harm to a resident due to medical care or lack of medical care). The findings are: R #1: A. Record review of R #1's face sheet revealed an admission date of 08/27/25 and included the following diagnoses:? Hepatic encephalopathy (a serious brain dysfunction caused by liver failure).Dysphagia (difficulty or discomfort in swallowing, as a symptom of disease).Gastro-esophageal reflux disease (GERD; A digestive disease in which stomach acid or bile irritates the food pipe lining).Alcoholic cirrhosis of liver (the most advanced form of liver disease related to excessive alcohol consumption).Dementia with behavioral disturbance (a group of conditions characterized by impairment of at least two brain functions, such as memory loss and judgment).Pneumonia (infection and inflammation of the lung).Secondary thrombocytopenia (is excess platelets in the bloodstream that develops as a result of another disorder).Vitamin D deficiency (low levels of vitamin D).Sequelae of cerebral infarction (the long-term effects and complications that can occur after a stroke).Chronic obstructive pulmonary disease (COPD; lung disease).Contracture (a shortening of muscles around joints causing joint stiffness and immobility) of right upper arm muscle, contracture of left upper arm muscle, contracture of right lower leg muscle, and contracture of left lower leg muscle.Cognitive communication deficit (a condition where a person's ability to communicate effectively is compromised by an underlying impairment in mental processes). Epileptic seizures (a brain condition that causes recurring seizures).History of suicidal behavior. B. Record review of R #1's baseline care plan dated 08/27/25 revealed the following health care needs were not addressed in the baseline care plan:? Dysphagia.Alcoholic cirrhosis of liver.Pneumonia.Secondary thrombocytopenia.Chronic obstructive pulmonary disease.Muscle contractures in all four limbs.Epileptic seizures.History of suicidal behavior. C. On 12/04/25 at 1:02 PM during an interview with the Director of Nursing (DON), she stated she was unsure why R #1's baseline care plan did not include dysphagia, alcoholic cirrhosis of liver, pneumonia, thrombocytopenia, COPD, Seizures, muscle contractures, and history of suicidal behaviors but confirmed those diagnoses should have been included in R #1's baseline care plan. The DON also stated it is the responsibility of the admitting nurse to review all documents for new admissions and include all relevant diagnoses in a baseline care plan. R #42:? D. Record review of R #42's face sheet revealed an admission date of 10/17/25 and included the following diagnoses: Major depressive disorder with psychotic features (a mental health disorder characterized by persistently depressed mood or loss of interest in activities, causing significant impairment in daily life, accompanied by a loss of touch with reality).Brief psychotic disorder (the sudden onset of psychotic behavior that lasts less than 1 month followed by complete remission with possible future relapses).Suicidal ideations (thoughts or considerations about ending one's life).Insomnia (a sleep disorder that can make it hard to fall asleep or stay asleep).Anxiety disorder (a group of mental health conditions characterized by excessive fear, dread, or apprehension).Pain.Generalized muscle weakness (reduction in the power exerted by muscles throughout the entire (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	body).Lack of coordination.Abnormalities of gait and mobility (deviations from normal walking patterns).Cognitive communication deficit. E. Record review of R #42's baseline care plan dated 10/27/25, revealed the care plan was developed ten days after admission and not within 48 hours as required. F. On 12/04/25 at 1:03 PM during an interview with the DON, she stated she expects care plans to be created within 48 hours. The DON confirmed the admission date for R #42 was 10/17/25 and the baseline care plan for R #42 was not created until 10/27/25.?

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to revise the plan of care following a confirmed change in condition for 1 (R #77) of 1 (R #77) resident reviewed for care plan revision when:R #77's care plan was not updated to include an orthopedic follow-up (evaluation and ongoing management by a bone and joint specialist to assess healing, treatment needs, and potential complications) and monitoring for safety and pain after R #77 returned from the hospital with a documented fracture requiring immobilization. This deficient practice likely to result in staff not having instructions to direct care, monitor changes, or implement safety interventions after a resident's injury or change in condition. The findings are: A.??????Record review of the facility's Person-Centered Care Plan Policy revised 09/15/25 revealed that residents have the right to be informed in advance of changes to the care plan, and the care plan must be revised after each assessment and upon changes in the resident's condition. The policy stated that a comprehensive person-centered care plan must include services to be furnished, measurable goals, timeframes, and individualized interventions based on identified needs. The policy further directs that 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)??must review and revise the care plan after a change in condition to ensure safe and appropriate delivery of care. B.??????Record review of R #77's face sheet revealed he was admitted into the facility on [DATE]. C.?????Record review of R #77's hospital discharge paperwork dated 11/19/25 revealed diagnostic imaging confirmed a right scapular spine (shoulder blade) fracture with nonunion a fracture that failed to heal properly, resulting in incomplete or absent bone healing), and directed the resident return wearing a sling, receive orthopedic follow-up on 11/26/25, and receive monitoring for pain and mobility changes. D.?????Record review of R #77's care plan dated 12/02/25 revealed the care plan was not revised to indicate the diagnosed fracture, no interventions for immobilization, no instructions directing staff to assist with transfers or mobility, and no pain-specific interventions related to the fracture. E.???????On 12/05/25 at 9:09 a.m., during an interview with Certified Nurse Aide (CNA) #4, she stated R #77 was supposed to use a sling, but R #77 did not consistently wear it and continued pushing himself up with the injured arm. She stated she had not been provided with any care plan direction or training regarding sling use or mobility precautions. F.?????On 12/05/25 at 9:51 a.m., during an interview with the Administrator (ADM), he stated the care plan should be revised when a resident returns from the hospital with new diagnoses and treatment requirements. He stated he was unaware of the fracture and stated the Director of Nursing (DON) was responsible for ensuring care plan updates. The ADM stated R #77's plan of care was not revised and stated monitoring did not occur and it is his expectation the revision of the care plan and the monitoring would have been performed. G.????On 12/05/25 at 12:32 p.m., during an interview with the Medical Director (MD), he stated he was aware R #77 had suffered a broken scapula. The MD also stated it was his expectation the facility would of follow the recommendations from the hospital and care plan all interventions.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews, and record review, the facility failed to ensure an environment free from accident hazards and failed to provide adequate supervision to prevent accidents for 2 (R #5 and R #38) of 2 (R #5 and R #38) residents reviewed for accidents and supervision when: The facility did not ensure staff maintained a safe room temperature, exposing R #5 and R #38 to 32-degree Fahrenheit (F) outside temperatures, when staff opened a window without consent and left the window open for an extended period of time. This deficient practice is likely to lead to residents experiencing avoidable accidents and/or injuries. The findings are:?R #5: A.??????Record review of R #5's face sheet revealed R #5 was admitted to the facility on [DATE] with diagnosis of unspecified dementia (a group of conditions characterized by impairment of at least two brain functions, such as memory loss and judgment). B.??????Record review of R #5's Quarterly Minimum Data Set (MDS; a federally mandated assessment instrument completed by facility staff) revealed R #5's Brief Interview of Mental Status (BIMS; a screening for cognitive impairment) score was 01 (00-07 is severe impairment) multiple mobility items coded as dependent, including Lying to sitting, Sit to stand, and Bed-to-chair transfer; indicating R #5 required complete staff assistance for all mobility. Additionally, (Walking 50 feet) and (Walking 150 feet) not attempted due to medical/safety concerns. R #38: C.?????Record review of R #38's face sheet revealed R #38 was admitted to the facility on [DATE] with the diagnosis having a lack of coordination (impaired ability to control voluntary muscle movements, which may affect balance, gait, transfers, and the ability to safely perform activities of daily living). D.????? Record review of R #38's Quarterly Minimum Data Set (MDS) revealed the following: R #38 had a Brief Interview for Mental Status (BIMS) score of 05 (defined as severe cognitive impairment, with scores of 00–07 indicating severe impairment). The MDS Section GG – Functional Abilities and Goals revealed R #38 was coded as dependent for the following activities: lying to sitting on side of bed, sit to stand, and bed-to-chair transfers, indicating staff were required to perform more than half of the effort necessary to complete these activities. The MDS further revealed walking activities were not attempted due to medical or safety concerns, indicating the resident was not clinically safe to ambulate at the time of the assessment. ?E.???????On 12/04/25 at 10:32 a.m., during an interview with R #5 and R #38, both residents were observed lying in their beds, while the room window remained open, and the curtain blew inward from the wind. The outside temperature measured 32 degrees F at the time of the observation, as verified using a mobile weather application. R #38's bed was placed right beneath the open window. Both residents stated they wanted the window closed because they were freezing. Neither resident demonstrated the physical ability to get up or close the window independently. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	?F.???????On 12/04/25 at 10:37 a.m., during an interview with Licensed Practical Nurse (LPN) #4, she stated neither R #5 nor R #38 was physically strong enough to close the window. She stated she did not know who opened the window in R #5's and R #38's room. ?G.?????On?12/04/25 at 10:38 a.m., during an interview with Certified Nursing Assistant (CNA) #4, she stated she opened the window approximately five minutes earlier to air out the room. She stated she did not request permission from either R #5 or R #38 before opening the window and stated she did not realize the temperature outside was 32 degrees F. CNA #4 stated she left the room after opening the window and confirmed neither of the residents were strong enough to close it. ?H.?????On?12/04/25 at 10:45 a.m., during an interview with the Director of Nursing (DON), she stated her expectation is that all resident windows remain closed unless a resident requests otherwise, and staff must educate the resident on the outside temperature before the resident makes an informed decision to open a window. She stated the residents could become sick with how cold the weather is and the window being left open. The DON confirmed the CNA should not have opened R #5's and R #38's window without their consent. ?I.????????On 12/05/25 at 11:15 a.m., during an interview with the Administrator (ADM), he stated it is his expectation all windows in the resident room would stay closed at all times.

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Red Rocks Care Center	3720 Church Rock Road Gallup, NM 87301

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on?record review and interviews,?the facility failed to ensure ongoing?communication and coordination with the resident's dialysis provider for 1 (R #4) of 1 (R #4) residents reviewed for dialysis.? If?the facility does not ensure consistent two-way communication with the dialysis center for every dialysis treatment,?then?the facility cannot ensure appropriate monitoring of the resident's dialysis-related condition, recognition of complications, or implementation of timely interventions. The findings are: A. Record review of the facility's Dialysis Policy dated 08/07/23 revealed facility nursing staff are required to complete ongoing assessments for the residents' condition and monitoring before and after dialysis treatments. B. Record review of R 4's face sheet revealed R #4 was admitted into the facility on [DATE] with the following diagnoses: Diagnosis of end stage renal disease,Dependence on renal dialysis. C. Record review of R #4's Care Plan, dated 04/22/23, revealed the following: Monitor dialysis labs.Monitor external hemodialysis catheter (tube placed in a vein that stays partly outside the body to allow temporary dialysis when kidneys aren't working properly). D. Record review of R #4's Order Summary Report, dated 12/05/25 revealed dialysis days Monday, Wednesday and Friday.? E. Record review of R #4's Electronic Health Record (EHR) Hemodialysis Communication forms dated 06/01/25 through 12/06/25 revealed only three dialysis communication forms were available for that timeframe (08/20/25, 08/25/25, and 09/15/25). R #4's EHR did not contain any other dialysis communication forms. F. On 12/07/25 at 11:51 am during an interview with Medical Records (MR), she stated all dialysis communication notes have been uploaded into the resident's chart and there is no outstanding documentation that is not scanned into R #4's medical record. G. On 12/06/25, at 11:44 AM, during an interview with the Director of Nursing (DON), she stated the facility uses a dialysis communication sheet which must accompany each resident from every dialysis appointment to ensure facility staff receive current clinical information from the dialysis clinic and the facility is updated on any changes with the residents. She stated dialysis communication was not consistent for R #4 and failure to communicate could result in missed information about episodes during treatment, irregular vital signs, or other issues which could lead to resident complications. The DON stated it is her expectation there is communication between the facility and the dialysis every appointment for the resident.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. Based on observation, and interviews, the facility failed to properly store medications in the facility medication cart and storage room by not: Ensuring the medication refrigerator (fridge) temperature log is being monitored routinely.Ensuring insulin (insulin is a natural hormone that turns food into energy and manages your blood sugar level) pens are dated when they are first used and dated 28 days after first use.These deficient practices are likely to result in expired medications and medical supplies being used in resident care resulting in residents being at risk of possible infections and not receiving the full benefits of medication. The findings are: A. On 12/01/25 at 11:38 am, observation of the locked medication room, the fridge temperature log form for the months of September through November 2025 were not complete. B. On 12/01/25 at 11:42 am, observation of the nurse medication cart revealed the insulin pens for R #'s 21, 36, 53, 56, and 72 were not dated with the date of first use and no date for when to discard after 28 days. C. On 12/01/25 at 11:42 am, during an interview with Registered Nurse (RN) #1, she confirmed the insulin pens are not dated when the pens were first used and dated for to discard after 28 days and it did not happen. RN #1 stated that undated insulin pens are considered expired and should be disposed appropriately. RN #1?confirmed that the fridge temperature logs were not complete and checked routinely as they should be. D. On 12/01/25 at 12:36 pm, during an interview with Director of Nursing (DON), she confirmed that nurses are expected to complete the fridge temperature log once a shift and it did not happen. DON also confirmed that undated insulin pens are considered expired and should not be in the carts.

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, the facility failed to provide a diet in accordance with physician orders for 1 (R #4) of 1 (R #4) resident reviewed for nutrition when:The facility did not ensure therapeutic dysphagia care (the clinical treatment of swallowing disorders using rehabilitative and compensatory interventions to improve swallowing function and reduce the risk of aspiration) was followed and sent R #4 to dialysis with food items (sandwich) inconsistent with his ordered renal/dysphagia advanced diet.Dietary staff and nursing leadership lacked awareness of and oversight over the contents of dialysis sack lunches, placing the resident at risk for aspiration and inadequate nutritional management. These deficient practices are likely to negatively impact a resident's ability to eat, causing difficulty with swallowing during mealtimes. The findings are:A. Record review of R 4's face sheet revealed R #4 was admitted into the facility on [DATE] with the following diagnoses: End stage renal disease?(ESRD; chronic irreversible kidney failure),Dysphagia?(difficulty or discomfort in swallowing, as a symptom of disease),Dependence on renal dialysis?(the process of removing extra fluid and waste products from the blood when the kidneys are not able to function properly). B. Record review of R #4's Care Plan, dated 04/22/23, revealed the following:? Provide Dysphagia Advanced (soft-textured diet for patients with swallowing disorders that includes foods requiring chewing but that are easy to swallow safely, helping reduce the risk of choking or aspiration) consistency, diet as ordered,Provide thin liquid consistency liquids as ordered,Monitor for sign/symptoms of aspiration i.e. coughing, watery eyes, choking, moist sounding voice, if?coughing occurs, no food/liquids until coughing resolves, Resident will be free from signs/symptoms of aspiration. C. Record review of R #4's Physician Order Summary Report, dated 12/18/24 revealed an order for a renal diet with dysphagia advanced texture (therapeutic diet prescribed for patients with kidney disease and swallowing disorders that provides soft, easy-to-chew foods while restricting nutrients such as sodium, potassium, phosphorus, and fluids, to support safe swallowing and proper renal management and reduce the risk of aspiration) standard thin liquids consistency.? D. On 12/04/25 at 11:05 AM, during an interview with R #4, he stated he leaves the facility at 9:15 AM for dialysis and returns around 2:45 PM on Mondays, Wednesdays, and Fridays. R #4 stated the facility sends him with a sack lunch containing a sandwich that he cannot eat because he could choke.E. On 12/04/25 at 11:15 AM, during an interview with the Dietary Manager (DM), she stated the facility sends a sack lunch with all dialysis residents. The DM stated R #4 receives a turkey or peanut butter sandwich, graham crackers, and applesauce in his sack lunch. She stated it is her responsibility to look at residents' diet orders, and it is her expectation for all diet orders to be followed.??? F. On 12/04/25 at 12:13 PM, during an interview with the Director of Nursing (DON), she stated R #4's diet was a renal/dysphagia advanced diet and confirmed he has a diagnosis of dysphagia. The DON stated R #4 is sent to dialysis on Mondays, Wednesdays, and Fridays. She stated she was unaware of what is included in the sack lunches sent with dialysis residents. She stated residents with a dysphagia/renal diet can eat a peanut butter sandwich but cannot eat a turkey sandwich due to sodium content and the potential for choking. She stated it is her expectation dysphagia diets are followed, and anything outside the dysphagia diet can cause a choking hazard.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to maintain accurate resident records for 5 of (R #'s 8, 37, 42, 90 and 95) of 5 (R #'s 8, 37, 42, 90 and 95) residents reviewed for accuracy of records by not: Ensuring weights were accurately documented for R #'s 8, 37, 42, and 90. Ensuring discharge documentation was updated and accurate for R #95. This deficient practice is likely to result in staff not having the information they need to provide competent, comprehensive care, and services to residents. The findings are: R #8: A. Record review of R #8's face sheet revealed an admission date of 11/08/23.? B. Record review of R #8's weight tracking revealed the following: 11/01/2025, the resident weighed 214.5 pounds (lbs.). 12/01/2025, the resident weighed 253.5 lbs. C. On 12/04/2025 at 1:02 PM during an interview with the Director of Nursing (DON), she confirmed the documented weights for R #8 and stated R #8's one month weight gain appears to be an error and R #8 should be re-weighed immediately. The DON stated it is her expectation that staff correctly document resident weights.? R #37: ?D. Record review of R #37's face sheet revealed an admission date of 05/10/21.? ?E. Record review of R #37's weight tracking revealed the following: 11/01/25, the resident weighed 125.0 lbs. 11/21/25, the resident weighed 63.0 lbs. ?F. On 12/04/2025 at 1:04 PM during an interview with the DON, she confirmed the documented weights for R #37 and stated R #37's significant weight loss in 20 days appeared to be a documentation error. She stated it is her expectation that staff correctly document resident weights.? R #42: G. Record review of R #42's face sheet revealed an admission date of 10/17/25.? H. Record review of R #42's weight tracking revealed the following:? 11/01/2025, the resident weighed 126 lbs. 11/21/2025, the resident weighed 725.4 lbs.? ?I. On 12/04/2025 at 1:05 PM during an interview with the DO, she stated R #42's 599.4-pound weight (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	gain in 20 days appeared to be a documentation error. She stated it is her responsibility to ensure the nurses are accurately documenting weights for residents.? R #90: J. Record review of R #90's face sheet revealed an admission date of 03/28/25.? K. Record review of R #90's weight tracking revealed the following:? 10/15/25, the resident weighed 71 lbs.? 11/01/25, the resident weighed 72 lbs.? 12/01/25, the resident weighed 127.5 lbs.? ?L. On 12/04/2025 at 1:08 PM during an interview with the DON, she stated R #90's documented weight gain within one month appears to be a documentation error. She stated it is her expectation that staff correctly document resident weights.? R #95: M. Record review of R #95's face sheet revealed R #95 was admitted to facility on 08/26/25. N. Record review of R #95's progress notes revealed a physician note, dated 11/16/2025, for R #95's discharge summary. Further review revealed R #95's discharge date was on 09/04/25. O. Record review of R #95's physician orders revealed an order, dated 09/04/25, for a referral to the hospital for a wound follow-up. P. Record review of R #95's minimum data set (MDS, which was part of the federally mandated process for clinical assessment of all residents in Medicare and Medicaid certified nursing homes) completed on 09/04/25 indicated R #95 was discharged to home/community. Q. On 12/05/2025 at 10:58 am, during an interview with Director of Nursing (DON), she stated R #95 was transferred out of the facility on 09/04/25 to the hospital. The DON stated she did not know why the physician discharge summary note was entered on 11/16/25 in R #95's progress notes, and she did not know why R #95's MDS showed R #95 was discharged to home/community. The DON stated she expected staff to complete R #95's discharge documentation accurately and consistently. The DON also stated it was the responsibility of the nurses to make sure assessments were accurate and the responsibility of the MDS coordinator to make sure the MDS was accurate. R. On 12/05/25 at 11:31 am, during an interview with the Administrator (ADM), he stated R #95 was originally scheduled to discharge home on [DATE]. The ADM stated staff noticed a change in condition for R #95 and he was sent out to the hospital on [DATE]. The ADM stated R #95's MDS should have reflected a discharge to the hospital rather than home. The ADM confirmed he expected all discharge documentation for R #95 to have been completed in an accurate and timely manner.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to maintain an infection prevention and control program designed to provide a safe and sanitary environment to prevent the development and transmission of communicable diseases and infections for 4 (R #3, R #55, R #71, and R #84) of 4 (R #3, R #55, R #71, and R #84) residents reviewed for infection control when: The facility failed to ensure staff performed hand hygiene during medication administration. The facility failed to ensure urinary catheter tubing remained off the floor to prevent contamination. The facility did not implement Enhanced Barrier Precautions (EBP) as required for residents with indwelling devices (inside the body) and wounds. The facility did not have biohazard bins or trash cans available for staff to discard used/soiled PPE (personal protective equipment). These deficient practices are likely to result in repeated and ongoing exposure of residents to increased risk of infection, cross-contamination, and injury. The findings are: Hand Hygiene: A. On 12/02/25 at 7:58 am, during a medication administration observation, Certified Medication Aide (CMA) #1 administered R #71's morning medications. Immediately afterward, CMA #1 proceeded to the medication cart to document her actions and started pouring the next residents without performing hand hygiene. B. On 12/02/25 at 7:58 am, during an interview with CMA #1, she confirmed that she forgot to perform hand hygiene after giving R #71's morning medications. CMA #1 stated that she is to perform hand hygiene after each medication administration as part of the facility infection control policy but did not happen. Catheter Tubing: R #3: C. Record review of the facility's Catheter Care Procedure (steps to maintain the catheter and drainage system - a thin, sterile tube inserted into the bladder to drain urine), last revised on 02/01/23, revealed procedure was to secure catheter tubing to keep the drainage bag below the level of the patient's bladder and off the floor. D. Record review of R #3's Face Sheet, revealed R #3 was originally admitted to the facility on [DATE] with diagnoses of Malignant Neoplasm (cancerous tumor) of Unspecified Kidney and Benign Prostatic Hyperplasia (enlarged prostate) with Lower Urinary Tract Symptoms. E. Record review of R #3's minimum data set (MDS, which was part of the federally mandated process for clinical assessment of all residents in Medicare and Medicaid certified nursing homes) completed on 07/08/25 indicated R #3 had a brief interview for mental status (BIMS; screening for cognitive impairment) score of 6 (00-07 is severe impairment). F. Record review of R #3's physician orders revealed an active order, dated 08/15/25, for Indwelling Foley catheter PRN (as needed) for chronic urinary retention or incontinence with discomfort. G. On 12/01/25 at 12:47 pm, during a dining room observation, R #3's catheter tubing dragged across the floor as he wheeled himself out of the dining room. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	H. On 12/02/25 at 12:25 pm, during an interview with Licensed Practical Nurse (LPN) #5, he stated the catheter tube for R #3 should not be dragged on the floor, as it could cause infection or the catheter tube could become caught and pulled out of the resident, causing discomfort. I. On 12/02/25 at 2:53 pm, during an interview with Director of Nursing (DON), she stated no catheter tubing should ever be dragged on the floor. The DON stated if the catheter tube is touching the ground, it could cause an infection, or the tube could get caught on something and pull the tube out of the resident. J. On 12/04/25 at 12:40 pm, during a hallway observation, R #3's catheter tubing dragged across the floor as he wheeled himself in the hallway.? K. On 12/05/25 at 11:58 am, during an interview with the Administrator (ADM), he stated resident catheter tubing should not be dragged across the ground, as it could get snagged and pull on the resident's appendage. The ADM also stated it is his expectation catheter tubing for residents would be properly secured under the residents' chair.? R #84: M. Record review of R #84's face sheet revealed he was admitted to the facility 10/31/25 with diagnoses of: Dementia (a group of conditions characterized by impairment of at least two brain functions, such as memory loss and judgement), History of traumatic brain injury (TBI; injury to the brain caused by an outside force, usually a violent blow to the head), Adult failure to thrive (a syndrome that describes a decline characterized by weight loss, decreased appetite, poor nutrition, inactivity and often accompanied by dehydration, depressive symptoms, and impaired immune function, among others.) N. Record review of R #84's Quarterly Minimum Data Set, dated [DATE] revealed a Brief Interview of Mental Status (BIMS; a screening for cognitive impairment) score of 02 (00- 07 is severe impairment). O. On 12/02/25 at 12:05 p.m., during a room observation, R #84 was observed to be seated in a wheelchair with the urinary drainage bag secured in a blue privacy bag off the floor; the catheter tubing between the resident and the bag extended was under the wheelchair and dragging across the floor surface. P. On 12/02/25 at 12:25 p.m., during an interview with Licensed Practical Nurse (LPN) #5, he stated the catheter tube should not be dragging on the floor as it could cause, and infection or the catheter tube could become caught and be pulled out of the resident causing discomfort for the residents. Q. On 12/02/25 at 2:53 p.m. during an interview with DON, she stated no catheter should ever have catheter tubing dragging on the floor. She stated if the tube is touching the ground, it could cause an infection, or the tube could get caught on something and pull the tube out of the resident. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R. On 12/05/25 at 12:38 p.m., during an interview with the ADM, he stated all catheter tubes should be properly secure for the residents below the bladder, without dragging the ground. He stated if the tube is dragging the ground, it could be pulled out and cause the residents' pain. ?EBP and Biohazard Bins: ? S. Record review of the facility's Enhance Barrier Policy, dated 01/06/20 revealed the following:? EBP are an infection control intervention designed to reduce the transmission of novel or MRDO (multi-drug-resistant organisms) Enhanced barrier precautions are infection control intervention designed to reduce the transmission of novel or MDRO. It employs targeted personal protective equipment (PPE) use during high contact resident activities,? To reduce the risk of transmission of epidemiologically important microorganisms by direct or indirect contact, EBP expands on the use of gown and gloves beyond anticipated blood and body exposures, focusing on use of gown and gloves only during high contact resident care activities that have been demonstrated to result in transfer of MDRO's to hands and clothing of healthcare personnel, even if blood and body exposure is not anticipated, Post the appropriate EPB sign of the resident's room door, EBP are to be utilized for the duration of the resident's stay, All residents with any of the following require EPB: Wounds and/or indwelling medical devices such as urinary catheter, EPB required during dressing, bathing/showering, transferring, providing hygiene, changing linens, changing briefs or assisting with toileting, device care or use, urinary catheter, Gown and gloves are used prior to high contact care, Change PPE before caring for another resident. R #3: ? T. On 12/05/25, at 9:09 AM, during an observation of R #3' s room, EBP signage was present on the outside of the room indicating staff are to utilize PPE when performing resident care. There was not a biohazard bin present (to throw away contaminated PPE) and there was only one trash can present in the room for R #3 and the roommate. U. On 12/05/25, at 9:13 AM, during an interview with Certified Nursing Assistant (CNA) # 1, she stated the red biohazard, or designated bin should be in the resident's room who are on EBP. She stated the two staff members providing care to R #3 should have PPE on while providing care to R #3. CNA #1 confirmed R #3 does not have a red biohazard bin, or designated trash can in the resident's room and should. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	V.?On 12/05/25, at 9:14 AM during an observation of R #3 in his room, the Assistant Director of Nursing (ADON)?and Medical Records (MR) were observed transferring R #3 from his wheelchair to his bed. No observation of PPE used by staff while providing care.? W.?On 12/05/25 at 9:17 AM, during an interview with the ADON, she stated she was unsure what the facility's policy was regarding Enhanced Barrier Precautions (EBP) and was not certain whether she was following EBP when providing care to R #3. She confirmed she had performed hand-to-hand contact (refers to direct physical contact between one person's hand and another person's hand) with the R #3 and acknowledged she should have been practicing EBP. She stated she was unsure if the care provided to R# 3 was consistent with EBP and was uncertain whether EBP needed to be followed when laying the resident down in bed. The ADON further stated if she was wearing PPE, she believed she would dispose of it in the trash located in the resident's room, but she was not sure. She stated residents on Active Isolation (deliberate separation of a patient with a contagious disease from others to prevent the spread of infection) require a red bin and room down the hall is where the facility's biohazard or designated bin is located. She noted there was only one trash can available for both residents in the shared room where she was providing care for R #3. The ADON stated it was her expectation all staff follow EBP to prevent the residents from declining or infection. R #55: X. Record review of R #55's face sheet revealed R #55 was admitted into the facility on [DATE] with the following diagnoses: Neuromuscular dysfunction of bladder (bladder doesn't work properly because of nerve or muscle problems, causing issues like leakage or trouble emptying), Retention of urine (a condition that occurs when a person is unable to empty their bladder, either partially or completely), Fracture of vertebra (break or crack in one of the bones of the spine, with routine healing (process by which a bone or tissue repairs itself after injury without complications). ?Y. Record review of R # 55's Care Plan, dated 11/12/25, revealed the following:? Resident has surgical wound on his back, Enhanced Barrier Precautions: Use gowns and gloves when performing high-contact activities: dressing, bathing and showering, transferring, providing hygiene, changing linens, changing briefs or assisting with toileting, device care or use of a device (urinary catheter, wound care (any skin opening requiring a dressing), Enhanced Barrier Precautions: Change PPE before caring for another resident, Enhanced Barrier Precautions: Educate patient/family and visitors regarding precautions, Resident is at risk for?Multidrug-Resistant Organism?(MDRO) colonization/infection due to: foley catheter. ?Z. Record review of R #55's Treatment Administration Record (TAR), dated 11/11/25 revealed the (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	following:? Change Indwelling Catheter when occluded or leaking as needed, Empty catheter drainage bag at least once every eight hours to when it becomes 1/2 to 2/3 full as needed, Perform Indwelling Catheter Care as needed, Wound(s): Monitor site(s) Daily for status of surrounding tissue and wound pain, Staple(s) removal on 11/18/25 one time only for Thoracic Lumbar (middle-to-lower back) incision. AA. On 12/02/25 at 8:24 AM, during an observation of R #55's room, EBP signage was present on the outside of the room indicating staff are required to utilize PPE when performing care.? BB. On 12/02/25 at 9:27 AM, during an observation of R #55's room, there was no biohazard bin to dispose of PPE.? CC. On 12/02/25 at 9:45 AM, during an observation of A-Hall, it was revealed no biohazard bin to dispose of PPE DD. On 12/03/25 at 12:02 PM, during an observation of A-Hall, reusable gowns for EBP use were observed to be available for staff use.? EE. On 12/03/25 at 2:30 PM, during an observation of R #55's room, Registered Nurse (RN) #1 not wearing?personal protective equipment (PPE; protective clothing, face masks, goggles, or other garments or equipment designed to protect the wearer's body from injury or infection)?while providing care to R #55. FF. On 12/04/25 at 11:31 AM, during an observation of A-Hall, no biohazard bins were observed to be available for staff use. GG. On 12/04/25, at 11:33 AM, during an observation of R #55's s room, there was not a red biohazard bin for staff use available. HH. On 12/05/25, at 7:50 AM during an observation of R #55's room, RN #2 was observed providing care to R #55 and was not wearing PPE as required. II. On 12/03/25, at 2:39 PM, during an interview with RN #1, she stated R #55 was on EBP for a foley catheter. She stated she was not using the proper PPE when providing care. RN #1 stated staff should use PPE and dispose after resident use in the biohazard bin or the trash bin. RN#1 stated there was no biohazard bins located in R #55's room. RN #1 confirmed it is her expectation for all staff to follow EBP standards of practice to prevent infections. JJ. On 12/05/25, at 7:52 AM, during an interview with RN #2, she stated she provided hand to hand contact with R #55 while checking his blood pressure. RN #2 stated R #55 was on EPB and her understanding of the EBP Policy required staff to gel in and gel out (use of hand sanitizer) and wear a gown, mask, and gloves.?RN #2 stated she was not following enhance barrier precautions, and there was not (continued on next page)

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	325070	A. Building B. Wing	12/05/2025

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

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	a red biohazard bin in R #55's room. The RN #2 stated she has received training (organized medical training for healthcare staff). She stated if enhance barrier precautions are not followed, the resident could get an infection. RN #2 stated it is her expectation there should be a red biohazard bin and trash located in R #55's room.? KK.?On 12/05/25, at 8:51 AM, during an observation of A-Hall, a red biohazard bin was not available for staff use. ?

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interviews, the facility failed to ensure there was a functioning call light system that allowed residents to call for assistance for 5 (1B, 25A, 26A, 27A, and 29A) of 5?(1B, 25A, 26A, 27A, and 29A) resident rooms observed for call light functionality. If the facility does not have a functioning communication system, then residents are unlikely to get their immediate needs met by facility staff.The findings are: A. Record review of the facility's Call Lights policy, last revised on [DATE], revealed residents will have a call light or alternative communication device at each patient's bedside, toilet, and bathing room to allow residents to call for assistance when unattended. Further review of policy revealed staff will report problems with a call light or call system immediately to the supervisor and/or Maintenance Director and will provide immediate or alternative solutions until the problem can be remedied (examples include replacing call light, providing a bell or whistle, increasing frequency of rounding, etc.).?? B. On [DATE] at 1:20 pm, observation revealed Call Lights above occupied resident room for 29A and unoccupied resident rooms, 27A, 26A, and 25A did not turn on when call buttons were pressed. C. On [DATE] at 12:20 pm, during an interview with the Maintenance Director (MD), stated call lights for Rooms 29A, 27A, 26A, and 25A should have worked. MD stated residents need to have call lights functioning in case they need any assistance. MD stated nurses may also tell maintenance directly of a repair needed and they will repair it right away. D. On [DATE] at 1:10 PM, during an observation of room [ROOM NUMBER]B, revealed the resident attempting to use her call light.?? E. On [DATE], at 1:37 PM, during an observation of room [ROOM NUMBER]B, CNA #1 was observed switching out the broken call light with a working call light.?? F. On [DATE], 12:20 PM, during an interview with the Maintenance Director (MD), stated call lights for Rooms 1B should have worked but it did not. The MD confirmed room [ROOM NUMBER]B's call light should have been replaced sooner but it was not.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview, the facility failed to ensure residents had a safe and functional environment throughout the facility and for 18 (RM's # 20, 22, 27, 41, 43, 46, 49, 50, 51, 54, 64, 65, 66, 67, 68, 70, 71, and 76) of 19 (RM's #4, 20, 22, 27, 41, 43, 46, 49, 50, 51, 54, 64, 65, 66, 67, 68, 70, 71, and 76) rooms observed when the facility failed to: Ensure the facility entrance wall was even and pain all facility walls that were unpainted.Repair broken trim around the heating/cooling unit and damaged floor tiles between resident beds, in room [ROOM NUMBER], 66.Repair seal around heating/cooling unit in room [ROOM NUMBER],66.Repair broken and uneven floor tiles in rooms 22, 41, 43, 45, 49, 50 and 51.Repair bathroom door frame trim in rooms 50, 54, 67, 68, 70 and 71.Repair baseboards in room [ROOM NUMBER].Ensure there were no lingering unpleasant odors throughout the facility.Repair of yellow expanding foal sealant in room [ROOM NUMBER].Repair of bathroom door with puncture hole in room [ROOM NUMBER].? These deficient practices are likely to expose residents to an unsafe and uncomfortable environment.The findings are:A-Hall: A. On 12/01/25, at 10:17 AM, during the initial tour of the facility and immediately upon entrance to the facility revealed a strong odor of urine and feces throughout the building including the A hall.? B. On 12/01/25 at 12:46 PM during an observation of A-hall, a strong odor of feces revealed throughout the entire hall.? C. On 12/04/25 at 11:45 AM during an observation of room [ROOM NUMBER], a strong odor of urine throughout this room; the dresser was broken; baseboard trim separated from walls and presence of a black substance behind and along the detached areas.?? D. On 12/04/25 at 12:15 PM during an observation of room [ROOM NUMBER] revealed the floor was uneven; broken floor tiles and baseboard trim separated from walls and presence of a black substance behind and along the detached areas.?? B-Hall: E. On 12/04/25 at 2:23 pm, observation revealed a wardrobe (a large cabinet used for storing clothes) in room [ROOM NUMBER] with the bottom left side of the door off its hinge. F. On 12/04/25 at 2:25 pm, observation in room [ROOM NUMBER] restroom revealed a cracked tile beside the toilet. Further observation revealed a black, dirt-like substance around back of toilet and splattered on the wall behind the toilet. G. On 12/05/25 at 12:20 pm, during interview with MD, he stated the wardrobe door in room [ROOM NUMBER] should not have the door off its hinge and should be repaired. MD stated the restroom in room [ROOM NUMBER] should not have any cracked tiles and should be in good repair. MD stated the facility served as the residents' home and the current environmental conditions did not support a homelike environment. C- Hall: (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	H. On 12/01/25 at 10:17 AM during the initial tour of the facility and immediately upon entrance to the facility revealed a strong odor of urine and feces throughout the building including the C-hall.? I. On 12/02/2025 at 8:46 AM during an observation of C-hall, revealed a strong odor of feces carried throughout the entire hall.? J. On 12/03/2025 at 1:35 PM during an observation of room [ROOM NUMBER] revealed a strong odor of urine throughout this room; frame on bathroom door appeared dirty and had scratches.? K. On 12/03/2025 at 1:40 PM during an observation of room [ROOM NUMBER], the heating/cooling unit was not completely sealed and daylight from the outside was visible; the wall next to the heating/cooling unit is cracked; the baseboard in the corner by the heating/cooling unit is broken; and there were cracked floor tiles by entry way.? L. On 12/03/2025 at 1:43 PM during an observation of room [ROOM NUMBER], the floor was uneven and there were broken floor tiles.? M. On 12/03/2025 at 1:45 PM during an observation of room [ROOM NUMBER], there were broken and uneven floor tiles throughout room; the bathroom door frame is broken; and the chair in this resident's room had torn upholstery on the seat.?? N. On 12/03/2025 at 1:48 PM during an observation of room [ROOM NUMBER], the dresser was broken; the?hallway floor next to room [ROOM NUMBER] has uneven broken/bubbling flooring.? O. On 12/03/2025 at 1:49 PM during an observation of room [ROOM NUMBER], cracked and uneven floor tiles were present throughout the room. P. On 12/03/2025 at 1:50 PM during an observation of room [ROOM NUMBER], a hole was present located on the bathroom door, and the dresser/drawer was broken with missing and loose handles.? Q. On 12/03/2025 at 1:52 PM during an observation of the hallway near room [ROOM NUMBER], unpainted patchwork was present on the wall. R. On 12/03/2025 at 1:54 PM during an observation of room [ROOM NUMBER], broken floor tiles were present throughout the room. S. On 12/03/2025 at 2:00 PM during an observation of room [ROOM NUMBER], the trim for the heating/cooling unit was broken and there were black build-up or scratches on the floor between resident beds. T. On 12/03/2025 at 2:03 PM during a C-Hall observation, the wall at the entrance to C-Hall had unpainted and uneven patchwork.? U. On 12/03/2025 at 2:05 PM during an observation of the main dining room revealed there was a broken light, missing pieces of the plastic light covering, and there was clear tape hanging off of it directly over a resident dining table. The wall and ceiling by the piano were cracked, there was a dirty ceiling vent directly?over a resident table, the exit door (to outside) had scratches and black scuff marks over the bottom half of the door; and the ceiling vent by the entrance door to dining (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	room appears dirty with black mold-like build-up.? V. On 12/05/2025 at 12:20 PM during an interview with the Maintenance Director (MD), he stated he was aware of the issues throughout the facility, and he acknowledged that some of the doors need to be replaced. He further stated he was aware of the broken floor tiles throughout the facility, and they have been working on this. The MD stated the cracking on the walls, ceilings and floors were related to issues with the building's foundation, and the building should be in better condition. He stated they are in the process of replacing all of the heating/cooling units in resident rooms and acknowledged most of the resident furniture was in disrepair and he will be ordering new furniture for resident rooms. Regarding the lighting in the main dining room, he stated he was aware of the broken light fixture as well as the cracks in the walls and floors and further stated they were in the process of getting new lighting and again reiterating the cracks are due to issues with the building's foundation.? Regarding the laundry room, he stated the damage to the wall was from water damage from water heaters that malfunctioned. He stated it was his expectation the drywall be repaired D-Hall: W. On 12/02/25 at 10:09 a.m. to 10:35 a.m., observation of D Hall revealed the following environmental concerns in occupied resident rooms: room [ROOM NUMBER], visible yellow expanding foam sealant was noted along the area where the baseboard meets the floor. The foam was uneven, excess material protruded outward, and the area had not been trimmed or finished. Rooms #67, #68, #70, and #71 revealed each bathroom door was missing trim along the lower portion of the door frame, resulting in an unfinished and irregular surface. room [ROOM NUMBER] revealed dresser/drawer was broken, lose drawer handle. room [ROOM NUMBER] revealed the bathroom door had a small, punctured hole located on the lower panel of the door. The hole contained rough and splintered edges and exposed interior material of the door surface. room [ROOM NUMBER] had a visible gap along the right-side perimeter of the unit where daylight was visible entering the room. The exposed opening showed deterioration of the wall surface, including a vertical crack extending upward from the top right corner of the unit. Observation further revealed the upper vertical plastic grill on the unit was bent and displaced. Sixth fluorescent light fixtures down the D-hall were broken and cracked.?? X. On 12/05/25 at 11:30 a.m., during an interview with the Maintenance Director (MD), he stated several doors need to be painted and that some doors are old. He stated the bathroom doors in Rooms 67, 68, 70, and 71 should not remain scuffed and the missing trim should be repaired. The Maintenance Director further stated the puncture hole in the bathroom door in room [ROOM NUMBER] should not be there and should be fixed because it does not look good for the residents. He stated room [ROOM NUMBER] should have had the yellow foam sealant should have been taken off.?