STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	325071	A. Building B. Wing	01/28/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aztec Healthcare	500 Care Lane Aztec, NM 87410

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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 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 review and interview, the facility failed to ensure the Minimum Data Set Minimum Data Set (MDS; a federally mandated assessment instrument completed by facility staff) was accurate for 1 (R #2) of 1 (R #2) resident reviewed for MDS accuracy. This deficient practice could result in failure to provide adequate care and treatment of the resident's needs. The findings are: A. Record review of R #2's face sheet, undated, revealed the resident was admitted into the facility on [DATE] with the following diagnoses: Unspecified dementia, unspecified severity, with other behavioral disturbance (a group of conditions characterized by impairment of at least two brain functions, such as memory loss and judgment), Unspecified symptoms and signs involving cognitive functions and awareness (problems with thinking, memory, or awareness that are noticed). B. Record review of R # 2's MDS, dated [DATE], revealed the following: Staff documented a Brief Interview for Mental Status (BIMS; screening for cognitive impairment) should be conducted. Staff did not document any answers for the BIMS section. C. On 02/09/26 at 4:08 PM, during an interview, the MDS Coordinator (MDSC) stated she was responsible for the completion of R #2's MDS assessments. She stated it was her expectation R #2's MDS assessments be fully completed, and staff should not leave the sections unanswered.

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure residents received the necessary treatment and services to prevent the development and worsening of pressure ulcers (PU; an injury to skin and underlying tissue resulting from prolonged pressure on the skin) for 1 (R #1) of 1 (R #1) resident when staff failed to: Begin wound care after identification of a coccyx (tailbone area; base of spine) wound.Administer wound care for R #1's coccyx pressure ulcer as ordered.Notify the facility Wound Care Nurse (WCN) and administrative nursing staff of R #1's worsening pressure ulcer and of the development of a new pressure wound on R #1's left ischial (hip bone) in a timely manner. These deficient practices likely resulted in R #1's pressure ulcer worsening with necrotic tissue (dead tissue) which required hospitalization for advanced wound care treatment. The findings are: A. Record review of R #1's Minimum Data Set (MDS; a federally mandated assessment instrument completed by facility staff), dated 10/24/25, revealed R #1 was admitted into the facility on [DATE] from the hospital. B. Record review of R #1's progress notes, revealed the following:Dated 10/23/25, R #1 had a treatable skin/wound present with dry skin to his lower left leg and healing from cellulitis (deep inflammation of the tissues just under the skin; caused by infection).Dated 10/24/25, nutrition note, R #1 did not have any wounds present per the facility wound report.Dated 10/25/25, R #1 had a treatable skin/wound present but additional information was not provided.Dated 10/27/25, R #1 had a treatable skin/wound present but additional information was not provided.Dated 10/28/25, R #1 had blood on his gown from his buttock. Staff documented R #1 had a new wound to his coccyx/sacrum. C. Record review of R #1's physician orders, dated October 2025, revealed the record did not contain wound care orders from 10/28/25 through 11/06/25. D. Record review of R #1's weekly skin checks, dated October 2025, revealed the following:Dated 10/29/25, staff documented a skin tear (a type of injury where the skin is torn from the body) to R #1's sacrum and the left and right gluteal folds (crease formed between the buttocks and the upper thigh). E. Record review of R #1's care plan revealed the following:Date Initiated: 11/06/25.Problem: Resident has potential /actual impairment to skin integrity related to fragile skin.Interventions: Apply barrier cream to buttocks every shift; Avoid scratching and keep hands and body parts from excessive moisture. Keep fingernails short; Pressure relieving/reducing mattress, pillows, to protect the skin while in bed; Pressure relieving/reducing mattress, pillows, to protect the skin while up in chair; Keep skin clean and dry. Use lotion on dry skin. Resident consistently self-determines to refuse wound assessment/wound care and offloading measures. F. Record review of R #1's MDS, dated [DATE] revealed the following:R #1 did not have any wound or pressure ulcer (PU; an injury to skin and underlying tissue resulting from prolonged pressure on the skin) present.R #1 was at risk of developing wounds/pressure ulcers.R #1 did not have any behaviors or behavior related concerns that would contribute to the development of a wound/pressure ulcer.R #1 required the use of a wheelchair.R #1 required substantial/maximal assistance for activities of daily living (ADL; activities related to personal care such as bathing, showering, dressing, walking, toileting, and eating). G. Record review of R #1's physician orders, dated November 2025, revealed the following orders: The record did not contain wound care orders from 10/28/25 through 11/06/25.Coccyx/sacrum wound: Start date 11/06/25: An order to cleanse with normal saline, skin prep (liquid when applied to the skin forms a protective film or barrier), and apply Medi-honey (medical grade honey used for wounds healing). Place super absorbent silicone dressing (foam dressing for wounds) every day shift Monday, Wednesday. and Friday. Order discontinued on 11/13/25.Coccyx/sacrum wound: Start date 11/13/25: An order to cleanse with normal saline, pack wound with Dakins soaked (an antiseptic solution used for wound cleaning and debridement) (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	packing. Place alginate (super absorbent dressing for wounds) dressing over wound bed, skin prep, and cover with silicone foam dressing, every day shift for wound care. Order discontinued on 12/01/25. H. Record review of R #1's Treatment Administration Record (TAR), dated November 2025, revealed the following: Coccyx/sacral wound: Dated 11/09/25 through 11/15/25: Staff did not document they administered wound care on 11/10/25. Staff did not document a code to show why the treatment was not administered.Coccyx/sacral wound: Dated 11/16/25 through 11/22/25: Staff did not document they administered wound care on 11/19/25. Staff did not document a code to show why the treatment was not administered.Coccyx/sacral wound: Dated 11/26/25 through 11/30/25: Staff did not document they administered wound care on 11/29/25 and 11/30/25. Staff did not document a code to show why the treatment was not administered. I. Record review of R #1's weekly skin checks, dated November 2025, revealed the following:Dated 11/05/25, staff documented skin tears to R #1's sacrum and perineal area (region located between the thighs in the front to the lower back). The skin tears were improving with assistance from staff in activities of daily living. Staff did not document any description for the resident's left and right gluteal fold skin tears.Dated 11/12/25, staff documented moisture associated skin damage (MASD; inflammation or loss of the top layer of skin due to continuous or prolonged moisture) to both right and left gluteal fold. Staff cleaned the area and applied wound dressing. Staff documented a Stage 3 pressure wound (full thickness skin loss that extends into deeper tissue and fat but not into muscle, tendon, or bone) to sacrum.Dated 11/21/25, staff documented MASD to both right and left gluteal fold. Staff cleaned the area and applied wound dressing. Staff documented a Stage 3 pressure wound to sacrum. J. Record review of R #1's wound assessments, dated November 2025, completed by the facility's Wound Care Nurse, revealed the following:Coccyx/sacral wound: Dated 11/04/25, the wound was moisture associated skin damage (MASD) from incontinence (loss of bladder or bowel control). The size of the wound was .50 length, .50 width, unknown depth. No odor or signs of infection.The WCN did not document an assessment for the week of 11/10/25.Coccyx/sacral wound: Dated 11/18/25, R #1's had a Stage 3 pressure ulcer, which measured 2.30 length, 4.30 width and unknown depth. There was heavy purulent excaudate (a thick, milky discharge that typically indicates an infection) with signs of infection. K. Record review of R #1's Nurse Practitioner (NP) notes, dated November 2025, revealed the following:R #1's NP evaluation, dated 11/06/25, was not available in R #1's electronic health record.Dated 11/13/25, revealed R #1 had a Stage 4 pressure ulcer (full thickness tissue loss with exposed bone, tendon, or muscle) to coccyx/sacrum, 100 percent slough (yellow stringy tissue adhered to wound bed), moderate purulent drainage. Measurements 4.6 centimeters (cm), by 3.1 cm. Wound culture (testing for infection in the wound) ordered and noted infection in the wound. The NP note indicated an initial wound evaluation for R #1's coccyx/sacrum, completed on 11/06/25, with the measurements 1.9 cm by 3.6 cm with a depth of 0.3 cm. The NP note indicated R #1's coccyx/sacrum wound required ongoing debridement (the removal of damaged tissue or foreign objects from a wound) since 11/06/25. The NP stated deep tunneling (a narrow channel or pathway that extends from the wound opening into deeper tissue layers which can complicate healing and increase the risk of infection) of R #1's coccyx/sacrum wound was present as of 11/13/25. The NP note did not address any other wound/skin issue.The record did not contain any other evaluations by the NP. L. Record review of R #1's Medical Doctor (MD) encounter progress note, dated 11/18/25, indicated R #1's coccyx/sacrum wound was infected and required antibiotics. M. Record review of R #1's nursing progress note, dated 11/20/25, revealed R #1 refused intravenous (IV; into the vein) antibiotic medications. The NP and nursing educated R #1 on the importance of IV antibiotics due to his worsening coccyx/sacrum wound, which was infected. Due to R #1's infected coccyx/sacrum wound and his refusal of antibiotics, R #1 was discharged (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	to the hospital on [DATE]. N. Record of R #1's discharge MDS revealed R #1 was discharged to the hospital on [DATE] with one unhealed Stage 3 (full thickness skin loss that extends into deeper tissue and fat but not into muscle, tendon, or bone) pressure ulcer. O. Record review of R #1's hospital records revealed the following:Dated 11/20/25, R #1 had a pressure ulcer with osteomyelitis (bone infection) to the coccyx/sacrum with hematuria (blood in the urine) and multifactorial sepsis (a complex and life-threatening condition caused by more than one of cause of where the body's immune response to infection leads to severe organ dysfunction). Dated 11/21/25, R #1's coccyx/sacrum had a strong odor with necrotic (dead) tissue present. R #1's coccyx/sacrum wound was measured to be 3 cm by 4.5 cm with a depth of 2 cm.Dated 11/22/25, R #1's coccyx/sacrum wound had developed necrotic yellow and gray tissue with deep red moist tissue. Debridement was scheduled so a wound VAC (vacuum assisted closure; applying negative pressure through a specialized device, which helps remove excess fluid and increase blood flow to the affected area, accelerating the healing process). P. Record review of R #1's readmission records revealed the following:An entry MDS, dated [DATE], R #1 was admitted into the facility from the hospital on [DATE].A completed admission MDS, with all care areas and treatments, was not completed after R #1's re-admission into the facility on [DATE]. Q. Record review of R #1's nursing progress notes, dated 12/05/25, revealed R #1 was re-admitted into the facility on [DATE] with wound VAC. R. Record review of R #1's care plan, in place after re-admission on [DATE], revealed the following:Initiated on 10/24/25:Focus: R #1 has the potential for skin tears related to fragile skin and decreased mobility.Interventions: R #1 needs a pressure-relieving mattress, pillows, to protect the skin while in bed.Initiated on 11/06/25:Focus: R #1 has potential/actual impairment to skin integrity related to fragile skin.Interventions: Apply barrier cream to buttocks every shift. Avoid scratching and keep hands and body parts from excessive moisture. Keep fingernails short. R #1 needs a pressure relieving/reducing mattress, pillows, to protect the skin while in bed. R #1 needs a pressure relieving/reducing mattress, pillows, to protect the skin while up in chair. Educate resident/family/caregivers of factors and measures to prevent skin injury. Encourage good nutrition and hydration in order to promote healthier skin. Keep skin clean and dry- use lotion on dry skin. S. Record review of R #1's nursing progress notes, dated 12/11/25, indicated R #1's coccyx/sacrum wound VAC was discontinued due to the resident having osteomyelitis and not receiving antibiotic medications. The NP's recommendation was to remove the wound vacuum. T. Record review of R #1's physician orders, dated December 2025, revealed the following:Coccyx/sacral wound: Dated 12/05/25: An order for wound vacuum. Flush with vashe (wound cleanser), cleanse with normal saline (NS), and apply wound vacuum. Change three days a week and as needed (PRN). Discontinued on 12/11/25.?Coccyx/sacral wound: Dated 12/11/25: An order to cleanse with NS, pack with calcium alginate rope (highly absorbent dressing for managing deep wounds and maintaining a moist environment), skin prep, and apply silicone foam dressing (foam dressing for wounds). Change three days a week and PRN. Discontinued on 12/26/25.Coccyx/sacral wound: Dated 12/26/25: An order for wound vacuum, flush with vashe, and cleanse with NS. Change every three days and as needed. Discontinued on 12/31/25.?Coccyx/sacral wound: Dated 12/31/25: An order to flush with vashe, cleanse with NS, pack with alginate rope, skin prep, and apply silicone foam dressing. Change every three days a week and as needed. U. Record review of R #1's TAR, dated December 2025, revealed the following: Coccyx/sacral wound: Dated 12/08/25 and 12/10/25: Staff completed the wound vacuum treatment. The order was discontinued on 12/11/25.Coccyx/sacral wound: Dated 12/11/25 and 12/26/25: Pack with calcium alginate rope (highly absorbent wound dressing made from seaweed fibers, designed to fill deep or narrow wounds while promoting moist healing) and apply silicone foam dressing. Staff did not document they administered wound care on 12/15/25 and 12/17/25. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Staff did not document a code to show why the treatment was not administered. V. Record review of R #1's weekly skin checks, dated December 2025, revealed the following:Dated 12/26/25, staff documented a pressure wound to left buttock. There were no other skin issues identified. W. Record review of R #1's wound assessments completed by the facility's Wound Care Nurse revealed the following:Coccyx/sacral wound: Dated 12/09/25, the wound was a Stage 3 pressure ulcer, which measured 3.0 length, 4.0 width and 4.70 depth. There was heavy purulent excaudate with signs of infection.Coccyx/sacral wound: Dated 12/29/25, the wound was a Stage 3 pressure ulcer, which measured 3.0 length, 4.0 width and 5.0 depth. There was heavy purulent excaudate noted with signs of infection.There were no other wound assessments completed for R #1 during December 2025. X. Record review of R #1's care plan revealed the following:Focus: R #1 has potential/actual impairment to skin integrity related to fragile skin.Interventions, initiated on 01/09/26: R #1 consistently self-determines to refuse wound assessment/wound care and offloading measures. Resident educated on risks of self-determined choices and expressed understanding and indicates he can take care of himself.Interventions, initiated on 01/14/26: R #1 re-educated on importance of asking for staff assistance with bed mobility/repositioning to reduce risk for skin damage related to shearing (injury where layers of the skin and underlying tissue slide past each other, causing deep tissue damage). R #1 expressed understanding and wishes to self-determine when he asks for assistance.Interventions, initiated on 01/15/26: R #1 re-educated/re-offered air mattress to help with pressure reduction and assist with wound healing/prevention. R #1 educated on risks of non-use. R #1 continues to decline air mattress. Y. Record review R #1's nursing progress note, dated 01/14/26, revealed the following: Staff completed a change in condition evaluation (the process of assessing and documenting any deviations from a patient's baseline health status) for a new skin wound/pressure ulcer.Staff documented they assisted R #1 back to his chair after his shower and the Wound Care Nurse observed sores on the resident's backside. Z. Record review of R #1's physician orders, dated January 2026, revealed the following:Left ischial wound: Dated 01/14/26, an order to cleanse R #1's wound to left buttock with normal saline and apply zinc to peri area of wound. Apply Dakin's (an antiseptic solution used for wound cleaning and debridement) soaked gauze and cover with silicone foam dressing. AA. Record review of R #1's TAR, dated January 2026, revealed the following:Coccyx/sacral wound: Staff did not document they completed the wound care to flush with vashe, pack with alginate rope, and apply silicone dressing every three days and as needed on 01/02/26, 01/07/26, 01/09/26, and 01/12/26. Left Ischial/buttock wound: Staff did not document they administered wound care on 01/15/26 and 01/16/26. Staff did not document a code to show why the treatment was not administered. BB. Record review of R #1's weekly skin checks, dated January 2026, revealed the following:Dated 01/02/26, staff documented right buttock pressure wound and edema on right lower leg.Dated 01/12/26, staff documented right buttock pressure wound and edema on right lower leg.R #1's Left Ischial/buttock wound was not identified nor documented during January 2026 skin checks. CC. Record review of R #1's wound assessments completed by the facility's Wound Care Nurse revealed the following:Coccyx/sacral wound: Dated 01/09/26, the wound was a Stage 3 pressure ulcer, which measured 3.0 length, 4.0 width and 5.0 depth. There was heavy purulent excaudate noted with signs of infection.Coccyx/sacral wound: Dated 01/14/26, the wound was a Stage 3 pressure ulcer, which measured 3.0 length, 4.0 width and 5.0 depth. There was heavy purulent excaudate noted with signs of infection.Left ischial wound: Dated 01/15/26, the wound was unstageable and measured 5.0 cm length, 10.0 cm width and the depth was unknown. The wound was 70% (percent) slough (dead, non-viable tissue) and was boggy (mushy or spongy-feeling area of the skin can be a sign of deep tissue injury and infection). DD. Record review of R #1's progress notes dated 01/16/26 indicated R #1 was sent to the hospital (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	on [DATE] due to a change in mental status related to a low blood pressure. EE. Record review of R #1's hospital records, dated 01/16/26 through 01/18/26, indicated the following:Chief complaint: leg pain and wound check.Patient reported left buttock and bilateral extremity pain which became progressively worse the past week. Patient in significant pain. R #1 underwent incision and drainage of left ischial ulcer and debridement (medical procedure to remove dead, damaged, or infected tissue from a wound to promote healing and prevent infection) of approximately: length 8 cm, width 5 cm, and 5 cm depth of necrotic tissue.Wound cultures have grown E. coli (bacterial infection) sensitive to ceftriaxone (antibiotic).R #1 will return to the operating room for additional debridement. After surgical debridement, R #1's wound was determined to be full thickness (wound extends into the deep layers of the skin). R #1's wound measurements were a length of 8.9 cm, a width of 8.9 cm, and a depth of 6.7 cm. FF. On 01/27/26 at 11:01 am during an interview, Certified Nursing Assistant (CNA) #1 stated R #1 had a wound on his bottom, and she thought it was on the right side under the right butt cheek. She stated the first time she saw the right buttock wound was sometime in December 2025, and she believed she reported it to the nurses. CNA #1 stated R #1 did not like to be turned in bed, but he would allow the nursing staff to turn him slowly for brief changes. CNA #1 confirmed R #1 experienced significant pain when he was respositioned in bed. GG. On 01/27/26 at 11:15 am, during an interview, CNA #5 stated he changed R #1 a few times, but he did not recall if R #1 had a wound. He stated R #1 was able to move on his own in bed and transfer himself. HH. On 01/27/26 at 11:43 am, during an interview, CNA #4 stated she worked with R #1 and saw two wounds on his buttocks. CNA #4 confirmed R #1 would refuse care at times due to pain. She stated she could not remember exactly when she saw the wounds, but there was a lot of redness around the wound. She stated one of the wounds had a smell to it, which she informed the nurse about. She stated if the wounds were worse or something had changed, she would notify the nurse about it. II. On 01/27/26 at 12:48 pm, during an interview, the Assistant Director of Nursing (ADON) stated she learned of R #1's left ischial wound on 01/14/26 from the WCN. The ADON stated she was unaware of R #1's wound prior to 01/14/26. The ADON stated the wound did not develop overnight, and it was missed by staff. The ADON stated staff should have notified the WCN and herself sooner. The ADON stated it was expected staff would provide R #1's wound care orders consistently. JJ. On 01/27/26 at 12:52 pm, during an interview, the Wound Care Nurse stated nurses who identify wounds were responsible to enter the basic orders for wound care. She stated orders should have been in place for the first wound on R #1's sacrum/coccyx on 10/28/25. She stated she was not aware of the first wound on R #1's sacrum/coccyx until 11/04/25, when she completed a wound evaluation. The WCN stated staff did not complete any orders or treatment for R #1's sacrum/coccyx wound from 10/29/25 to 11/07/25. She stated the treatments were also not completed on 11/10/25 or 11/12/25. The WCN stated the R #1's coccyx/sacrum wound had an odor present and looked infected when she did her wound assessment on 11/18/25. She stated R #1 was sent out to the hospital on [DATE] because the wound had osteomyelitis. She stated she was responsible for the wound care being completed and for weekly wound assessments, and the nurses were also responsible for the wound care. She stated all staff were responsible for reporting any new or changed skin issues they observe. She stated wound assessments should be completed by the nurses weekly. The WCN stated wound care should be done and completed as ordered, unless R #1 refused the wound care. The WCN stated R #1 did refuse care, including the air mattress because he did not like it. She stated R #1 refused IV antibiotics because he wanted a pill form of the antibiotic. She stated R #1 would also refuse to turn in bed. The WCN stated she identified R #1's left ischial wound on 01/14/26. She stated she was shocked because of how R #1's left ischial wound was presented. The WCN stated there was not any information about R (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	#1's left ischial wound in the electronic health record, and she was not aware of the findings on the 12/26/25 skin check. She stated she was unaware of how long the left ischial wound had been there. The WCN stated it was the responsibility of each nurse to complete a weekly skin assessment. The WCN stated the facility nursing staff should have notified her of R #1's left ischial wound sooner, but they did not. KK. On 01/28/26 at 1:00 pm, during an interview, R #1 confirmed he required facility staff assistance when moving, including when he was in bed. LL. On 03/12/26 at 12:29 pm, during an interview, the ADON stated there should not have been any delays regarding R #1's Coccyx/sacral wound treatment. MM. On 03/12/26 at 12:55 pm, during an interview, the ADON stated the WCN initially documented the wrong location for R #1's wound on 12/26/25. She stated the facility nurses did not understand the skin assessment processes, which is something she is now working on. The ADON confirmed R #1's left ischial wound should have been identified sooner with wound care treatment orders provided before 01/14/26. The ADON also confirmed the wound care treatment for R #1 did not meet her expectations. The ADON stated wound care treatment orders should be followed and documented on the TAR. The ADON stated if staff left a resident's TAR blank without specific codes, she could not determine if the wound care was completed as ordered. NN. On 03/12/26 at 12:56 pm, during an interview, the Director of Nursing (DON) stated staff should document wound care treatments on the residents' TAR when they completed the treatment or enter a code to show the resident refused.