STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	325073	A. Building B. Wing	12/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Socorro Wellness & Rehabilitation	1203 Highway 60 West Socorro, NM 87801

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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 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure residents did not receive psychotropic medications (group of drugs that affect behavior, mood, thoughts, or perception) unless there was adequate monitoring for any adverse consequences resulting from the medication for 1 (R #8) of 5 (R #3, R #8, R #25, R #36, and R #70) residents reviewed for unnecessary medications, when staff failed to: 1. Ensure psychotropic medications were prescribed to treat a specific psychiatric diagnosis (mental illness, symptoms or condition that greatly disturbs your thinking, moods, and/or behavior). 2. Perform an AIMS (Abnormal Involuntary Movement Scale test used in medicine to assess side effects of antipsychotic medication) assessment to monitor antipsychotic (a class of psychotropic medication primarily used to manage psychosis, principally in schizophrenia but also in a range of other psychotic disorders) medication. These deficient practices could likely result in residents receiving medications without a medical reason and being at a higher risk of adverse side effects (unwanted, harmful, or abnormal result). The findings are: A. Record review of R #8's admission documents, no date, revealed the following: 1. R #8 was admitted to the facility on [DATE]. 2. R #8 had the following diagnoses: a. Senile degeneration of brain (an outdated term for age-related cognitive decline, now called dementia, a progressive loss of brain function due to damaged brain cells, most commonly from Alzheimer's, vascular issues, or Lewy body disease, causing memory loss, confusion, and impaired thinking, rather than being a normal part of aging itself). b. Major Depressive Disorder (MDD, a serious mood disorder causing persistent sadness, loss of interest, and impaired daily functioning). c. Personal history of other mental and behavioral disorders (a medical classification, often using the ICD-10 code Z86.59, that indicates a patient has a history of past mental health issues). d. Anxiety (excessive worry, restlessness, rapid heart rate, trouble concentrating, and sleep issues). e. Dementia f. Restlessness and agitation (states of inner tension and inability to stay still). B. Record review of R #8's physician orders, multiple dates, revealed the following: 1. An order dated 09/08/25 and discontinued on 09/15/25, for quetiapine fumarate (an atypical antipsychotic medication used to treat schizophrenia and bipolar disorder) 50 mg two times a day for agitation. 2. An order dated 10/20/25, for quetiapine fumarate 50 mg twice a day for agitation and anxiety. C. Record review of R #8's MAR, dated September 2025, revealed R #8 received quetiapine fumarate as ordered from 09/08/25 to 09/15/25. D. Record review of R #8's MAR, dated October 2025, revealed R #8 received quetiapine fumarate as ordered from 10/22/25 to 10/31/25. E. Record review of R #8's MAR, dated November 2025, revealed R #8 received quetiapine fumarate as ordered the entire month. F. Record review of R #8's MAR, dated December 2025, revealed R #8 received quetiapine fumarate as ordered from 12/01/25 to 12/12/25. G. Record review of R #8's entire medical record, no date, revealed the following: 1. No order for AIMS assessment, and 2. No AIMS assessment had been documented. H. On 12/12/25 at 2:35 PM, during an interview, the Regional Clinical Nurse (RCN) confirmed the following: 1. R #8 had an (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	order for quetiapine fumarate for agitation and anxiety. 2. R #8 did not have an appropriate diagnosis for the use of antipsychotic medication. 3. Staff were expected to ensure residents were not administered antipsychotic medication unless they had a specific psychiatric diagnosis. 4. Staff did not complete an AIMS assessment on R #8. 5. Staff were expected to complete an AIMS assessment prior to starting an antipsychotic medication and at least every three (3) months after.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to report allegations of misappropriation of resident funds (the deliberate misplacement, exploitation, or wrongful, temporary, or permanent use of a resident's money without the resident's consent) to the State Agency within 24 hours of allegation for 1 (R #36) of 2 (R #2 and R #36) residents reviewed for misappropriation of funds, when staff failed to report allegations of missing money. If the facility fails to report allegations of misappropriation of resident funds to the state agency within 24 hours of the allegation, then corrective action may not be taken, and residents may suffer increased anxiety and fear that their money is not being protected. The findings are: A. Record review of R #36's admission documents, no date, revealed R #36 was admitted to the facility on [DATE]. B. On 12/10/25 at 9:47 AM, during an interview, R #36's family member (FM) stated the following: 1. He gave Human Resources (HR) money to put in an account for R #36 shortly after she arrived (he did not know the date). 2. The previous facility that R #36 was at sent a check to the facility that was supposed to be placed in R #36's account. 3. He notified the MDS coordinator two or three months ago (2-3 months before surveyor interview) that the business office manager (BOM, acting as a central point for internal/external communication and problem-solving to support business goals and a productive environment) told him that there was no record of R #36 having a facility account or any money. C. Record review of the facility's Grievance Report, dated 10/23/25, revealed the following: 1. On 10/23/25, R #36's FM reported to the MDS coordinator that he had given the facility $140 to put in an account for R #36. 2. The money disappeared. D. Record review of the state agency (SA) incident reporting system, no date, revealed the SA did not receive an incident report regarding the allegation of misappropriation of resident funds for R #36. E. On 12/12/25 at 1:03 PM, during an interview, the Regional Director (RD) confirmed the following: 1. The facility did not report the allegation of misappropriation of resident funds to the SA. 2. The facility administrator was expected to report allegations of misappropriation of resident property or funds to the SA within 24 hours of the allegation.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to thoroughly investigate an allegation of misappropriation of resident funds (the deliberate misplacement, exploitation, or wrongful, temporary, or permanent use of a resident's money without the resident's consent) 1 (R #36) of 2 (R #2 and R #36) residents reviewed for misappropriation of resident funds when staff failed to have evidence of a thorough investigation of misappropriation of resident funds. If the facility does not adequately investigate allegations of misappropriation of resident funds, then corrective action is not implemented to protect other residents from misappropriation of resident funds, then residents may suffer increased anxiety and fear that their money is not being protected. The findings are: A. Record review of R #36's admission documents, no date, revealed R #36 was admitted to the facility on [DATE]. B. On 12/10/25 at 9:47 AM, during an interview, R #36's family member (FM) stated the following: 1. He gave Human Resources (HR) money to put in an account for R #36 shortly after she arrived (he did not know the date). 2. The previous facility that R #36 was at sent a check to the facility that was supposed to be placed in R #36's account. 3. He notified the MDS coordinator two or three months ago (2-3 months before surveyor interview) that the business office manager (BOM, acting as a central point for internal/external communication and problem-solving to support business goals and a productive environment) told him that there was no record of R #36 having a facility account or any money. C. Record review of the facility's Grievance Report, dated 10/23/25, revealed the following: 1. On 10/23/25, R #36's FM reported to the MDS coordinator that he had given the facility $140 to put in an account for R #36. 2. The money disappeared. D. On 12/12/25 at 1:03 PM, during an interview, the Regional Director (RD) confirmed the following: 1. The facility did not have evidence that a thorough investigation was conducted for the allegation of misappropriation of R #36' funds. 2. The facility administrator was expected to conduct a thorough investigation for all allegations of misappropriation of resident property or funds.

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to provide the required discharge or transfer information to the resident and the resident's representatives in writing for 3 (R #2, R #5, and R #66) of 3 (R #2, R #5, and R #66) residents sampled for hospitalizations, when staff failed to: 1. Notify the residents and resident representative(s) of the resident's transfer to the hospital in writing and in a language and manner they understand for R # 2 and R #5. 2. Ensure residents or their representative received a written notice of the bed hold policy which indicated the duration the bed would be held for R #66. These deficient practices could likely result in the resident and/or their representative not knowing the reason for a transfer or discharge, the location of the transfer or discharge, their rights to advocate and make informed decisions regarding the resident's healthcare, the services that the resident received while at the facility, the resident's current health status, or the resident's current medications leading to adverse outcomes for the resident. The findings are: R #2 A. Record review of R #2's admission documents, no date, revealed R #2 was admitted to the facility on [DATE]. B. Record review of R #2's progress note, dated 08/18/25, revealed R #2 was sent to the hospital due to weakness. C. Record review of R #2's entire medical record, no date, revealed staff did not document a notice of transfer for R #2's transfer to the hospital on [DATE]. D. On 12/12/25 at 9:24 AM, during an interview, the Regional Clinical Nurse (RNC) confirmed the following: 1. Staff did not complete a transfer notice and should have for R #2's transfer to the hospital on [DATE]. 2. Staff were expected to complete a written transfer notice when a resident was transferred to the hospital and give a written copy of the transfer notice to the resident or their representative. R #5 E. Record review of R #5's admission documents, no date, revealed R #5 was admitted to the facility on [DATE]. F. Record review of R #5's progress note, dated 06/09/25, revealed R #5 was sent to the hospital due to hypotension (low blood pressure, where blood pressure readings are below the normal range). G. Record review of R #5's entire medical record, no date, revealed staff did not document a transfer notice for R #5's transfer to the hospital on [DATE]. H. On 12/15/25 at 9:36 AM, during an interview, the RNC confirmed that there was not a transfer notice documented in R #5's medical record. The RNC stated that when a resident is transferred a notice (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	should be provided to the resident or their representative. R #66 I. Record review of R #66's face sheet revealed the following admission date of 07/10/25. J. Record review of R #66's progress note dated 09/04/25 revealed resident was admitted to the hospital and had a Computed Tomography (CT scan that uses X-rays and computer to create detailed cross-sectional images of inside the body) done revealing Pyogenic Arthritis of the right hip (known as septic arthritis, a serious condition characterized by inflammation of the hip joint due to bacterial infection). K. Record review of progress notes dated 09/04/25 and 09/05/25 revealed on 09/05/25 at 11:14 PM Resident had not returned from dialysis. Finally called the hospital to look for resident. Resident was admitted to the emergency room (ER) at 5:05 pm via ambulance from the Dialysis Center. CT revealed Pyogenic Arthritis of the R (right) hip. Resident will be transferred out to (name of hospital). Nurse from the emergency room will call back with final report. L. On 12/11/25 at 5:01 PM, during an interview, the Social Service Worker (SSW) stated R #66 was sent to the hospital from dialysis, and the facility was not told by dialysis center that they sent resident out. SSW called dialysis center and was told R #66 was sent to hospital. SSW stated that R #66's family came into the facility when R #66 was in the hospital and stated they wanted R #66 to transfer to (name of nursing home) because that facility was a better fit for R #66. SSW stated that R #66's family picked up his personal belongings and left the facility. SSW stated she does not remember alerting the ombudsman when R #66 transferred to another nursing home. SSW stated she is the admission Coordinator, but nursing does the admission documentation for bed holds and transfer and nursing communicates to the physician to obtain orders. M. On 12/12/25 at 11:43 AM, during an interview with the Regional Clinical Nurse, she stated R #66 was transferred to the hospital from dialysis, and there was no bed hold notice in R #66 record. The Regional Clinical Nurse confirmed that her expectation is that staff complete the NM bed hold notice.

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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 observation, interview, and record review, the facility failed to ensure the Minimum Data Set Assessment (MDS; federally mandated assessment instrument completed by facility staff) was accurate for 1 (R #36) of 8 (R #4, R #5, R #6, R #7, R #10, R #17, R #36, and R #60) residents reviewed for dental care. This deficient practice could likely result in the facility not having an accurate assessment of the residents' needs. The findings are: A. Record review of R #36's admission documents, no date, revealed R #36 was admitted to the facility on [DATE]. B. On 12/10/25 at 9:59 AM, during an interview, R #36's family member (FM) stated that R #36 had top dentures when she came to the facility and was missing her bottom dentures prior to admission. C. On 12/12/25 at 9:43 AM, during an observation and interview of R #36, the following was revealed: 1. R #36 stated she did not have any teeth or dentures. 2. R #36 stated she had dentures, but she was not sure what happened to them. 3. R #36 was observed to not have any of her own teeth and she was not wearing dentures. D. On 12/12/25 at 9:44 AM, during an interview, CNA #16 stated that R #36 did not have any dentures. E. Record review of R #36's admission MDS, dated [DATE], revealed staff did not document that R #36 was edentulous (lacking teeth). F. On 12/12/25 at 9:47 AM, during an interview, the MDS Coordinator confirmed the following: 1. R #36 did not have her own teeth or dentures since admission. 2. Staff did not document on R #36's admission MDS that she was edentulous. 3. R #36's admission MDS was inaccurate, and staff should have documented that R #36 was edentulous.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to develop an accurate, person-centered comprehensive care plan for 4 (R #2, R #25, R #69, and R #70) of 5 (R #2, R #7, R #25, R #69, and R #70) residents reviewed for comprehensive care plans (plan that has measurable goals and timeframes to meet a resident's medical, nursing, mental health and psychosocial needs). This deficient practice could likely result in staff being unaware of the current and actual needs of the residents. The findings are: R #2 A. Record review of R #2's admission documents, no date, revealed the following: 1. R #2 was admitted to the facility on [DATE]. 2. R #2 had the following diagnoses: a. Infection and inflammatory reaction due to indwelling ureteral stent (infection or swelling due to a thin, flexible tube placed in the ureter (the tube from kidney to bladder) to keep it open, allowing urine to flow past blockages like kidney stones or after surgery, often causing symptoms like frequent urination, burning, urgency, or blood in urine). b. Calculus of kidney (a hard deposit of minerals and salts (like calcium, oxalate, uric acid) that forms in the kidneys when urine becomes too concentrated). c. Calculus of ureter (a kidney stone that has moved into the ureter, the tube connecting the kidney to the bladder, causing severe, colicky pain (renal colic) in the flank, abdomen, and groin, often with nausea, vomiting, and blood in the urine). d. Obstructive and reflux uropathy (blocks urine flow, causing backup (hydronephrosis) and potential kidney damage, while vesicoureteral reflux (VUR) (a type of obstructive uropathy) is urine flowing backward from bladder to kidneys, often due to faulty valves). B. Record review of R #2's physician order, dated 08/23/25, revealed the following: 1. An order to change foley catheter (a thin, flexible tube inserted into the bladder through the urethra to drain urine) every 30 days. 2. An order for foley catheter care (strict hygiene, cleaning the insertion site daily with soap and water, keeping the drainage bag below bladder level, ensuring tubing is free of kinks, and staying hydrated to prevent urinary tract infections (UTIs) and blockages, always washing hands before and after handling to reduce germ spread) every shift. 3. An order to change foley catheter as needed for leakage or drainage. 4. An order to irrigate (the process of injecting a sterile solution (like saline) into the catheter tube to clear blockages from mucus, blood clots, or debris, ensuring it stays open and drains properly, preventing complications) catheter as needed. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	C. Record review of R #2's care plan, dated 08/18/25, revealed the care plan did not include interventions for: 1. Staff to provide catheter care for R #2's foley catheter every shift. 2. Staff to change R #2's foley catheter every 30 days. 3. Staff to change R #2's foley catheter as needed. 4. Staff to irrigate R #2's foley catheter as needed. D. On 12/12/25 at 9:35 AM, during an interview, the MDS coordinator confirmed R #2's care plan did not include interventions for caring for R #2's foley catheter and should have. E. On 12/12/25 at 11:22 AM, during an interview, the Regional Clinical Nurse (RNC) confirmed staff should document all interventions for caring for a resident's catheter in the care plan. R #25 F. Record review of R #25's admission Record (no date) revealed the following: 1. R #25 was admitted to the facility on [DATE]. 2. R #25 had a diagnosis of chronic pain syndrome (pain that persists beyond the normal healing time, typically lasting 3 to 6 months or longer and often includes additional symptoms such as depression and anxiety which can interfere with daily life). G. Record review of R #25's physician's orders revealed an order dated 09/09/25, for Suboxone sublingual film (combination opioid medication that is designed to dissolve under the tongue and is used by some healthcare providers to manage chronic pain) 4-1 mg give 1 film sublingually (under the tongue) three times a day related to chronic pain syndrome. H. Record review of R #25's care plan, dated 09/09/25, revealed staff did not document in the care plan that R #25 was taking the opioid medication Suboxone. I. On 12/12/25 11:50 AM, during an interview, the RCN confirmed the following: 1. R #25's care plan did not include a plan for the medication Suboxone. 2. Her expectation is that the care plan would have a specific plan in place for this type of medication. R #69 J. Record review of R #69's admission documents, no date, revealed the following: 1. R #69 was admitted to the facility on [DATE]. 2. R #69 had the following diagnoses: (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	a. Chronic Obstructive Pulmonary Disease (COPD) a progressive lung disease making breathing difficult). b. Chronic respiratory failure with hypoxia (a long-term condition where the lungs can't supply enough oxygen to the blood). c. Solitary pulmonary nodule (a small, round spot in the lung). d. Dependence on supplemental oxygen (body needs extra oxygen to keep organs healthy due to low blood oxygen (hypoxemia), often from lung diseases like COPD). K. Record review of R #69's physician order, dated 11/13/25, revealed the following: 1. An order for Albuterol-Budesonide Inhalation Aerosol (is a dual-action prescription medication used as a rescue inhaler for adults with asthma) give two (2) puffs every four (4) hours as needed for shortness of breath (SOB). 2. An order for oxygen via nasal cannula at a rate of six (6) to eight (8) liters per minute (LPM, oxygen flow rate) for COPD. 3. An order to raise the head of the bed or provide a pillow while resident was in bed for shortness of breath due to COPD. 4. An order to change oxygen tubing and oxygen concentrator filter every week. L. On 12/11/25 at 10:26 AM, during an interview with LPN #17, she stated the following: 1. R #69 used a special high flow nasal cannula. 2. R #69's nasal cannula had two ports that connected to two oxygen concentrators. 3. R #69 required two oxygen concentrators to deliver his oxygen through the special high flow nasal cannula. M. Record review of R #69's care plan, dated 11/17/25, revealed the following: 1. Staff did not document in the care plan that R #69 required a special high flow nasal cannula to deliver his oxygen. 2. Staff did not document in the care plan that R #69 required the use of two oxygen concentrators. 3. Staff did not document in the care plan that R #69's nasal cannula or oxygen concentrator filter needed to be replaced every week. 4. Staff did not document in the care plan that R #69 needed the head of the bed elevated or pillows behind his back when in bed. 5. Staff did not document in the care plan that R #69 had an order for Albuterol-Budesonide when he (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	had shortness of breath. N. On 12/11/25 11:51 AM, during an interview, the ADON confirmed the following: 1. R #69's care plan did not include his orders for Albuterol-Budesonide. 2. R #69's care plan did not include orders to elevate R #69's head of bed or give a pillow when in bed. 3. R #69's care plan did not include that he required a special high flow nasal cannula. 4. R #69's care plan did not include that his nasal cannula and oxygen concentrator filter needed to be replaced weekly. 5. Staff were expected to document all interventions that were in place to help a resident's respiratory status on the care plan. R #70 O. Record review of R #70's electronic medical record (EMR) revealed the following: 1. R #70 was readmitted to the facility on [DATE]. 2. R #70 had a diagnosis of pulmonary embolism (blockage in one of the pulmonary arteries in the lungs, usually caused by blood clots that travel from the legs or other parts of the body). P. Record review of R #70's physician's order revealed an order dated 11/11/25, for Apixaban tablet (anticoagulant medication used to prevent and treat blood clots, commonly prescribed to treat conditions such as pulmonary embolism) give 5 mg two times a day for blood thinner. Q. Record review of R #70's care plan, dated 09/09/25, revealed staff did not document in the care plan that R #25 was taking Apixaban for history of pulmonary embolism and the risks associated with this medication. R. On 12/12/25 at 11:52 AM, during an interview, the RCN confirmed the following: 1. R #25's care plan did not include a plan for the medication Apixaban. 2. Her expectation is that the care plan would have a specific plan in place for this type of medication and include the risks associated with this medication.

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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 observation, and interview, the facility failed to ensure care plan revisions occurred for 6 (R #7 R #8, R #17, R #25, R #36, and R #60) of 8 (R #5, R #6, R #7, R #8, R #17, R #25, R #36, and R #60) residents reviewed for care plan accuracy when the staff failed to revise the care plan with the most current resident information. This deficient practice could likely result in the care plan not being updated with the most current resident conditions and appropriate interventions, staff being unaware of changes in care provided, and residents not receiving the care related to changes in their health status or healthcare decisions. The findings are: R #7 A. Record review of R #7's admission record, no date, revealed the following: 1. R #7 was admitted to the facility on [DATE]. 2. R #7 had the following diagnoses: a. Chronic respiratory failure with hypoxia (lungs consistently can't get enough oxygen into the blood). b. Simple chronic bronchitis (a condition causing a persistent, mucus-producing cough for months, often linked to smoking or irritant exposure). B. Record review of R #7's physician's orders, multiple dates, revealed the following: 1. An order dated 08/21/24, for oxygen via nasal cannula (a simple, common medical device with two soft prongs that fit into the nostrils, delivering supplemental oxygen or increased airflow from a supply source (like an oxygen concentrator) through a tube) at one (1) to two (2) liters per minute (LPM, flow rate of oxygen). 2. An order dated 10/17/25 to change oxygen tubing and water on oxygen concentrator (a medical device that provides concentrated oxygen to people with breathing problems by taking in ambient air, removing nitrogen and impurities, and delivering purified, oxygen-enriched air through a nasal cannula or mask) and portable oxygen tank every week. C. Record review of R #7's care plan, dated 08/27/25, revealed staff did not include interventions in place for R #7's order for oxygen or for changing R #7's nasal cannula weekly. D. On 12/12/25 at 3:20 PM, during an interview, the RNC confirmed the following: 1. R #7's care plan did not include resident's order for oxygen or to change his nasal cannula weekly. 2. Staff were expected to document oxygen orders in resident care plans. 3. Staff were expected to document orders for changing resident nasal cannula in the care plan. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R #8 E. Record review of R #8's admission documents, no date, revealed the following: 1. R #8 was admitted to the facility on [DATE]. 2. R #8 had the following diagnoses: a. Senile degeneration of brain (an outdated term for age-related cognitive decline, now called dementia, a progressive loss of brain function due to damaged brain cells, most commonly from Alzheimer's, vascular issues, or Lewy body disease, causing memory loss, confusion, and impaired thinking, rather than being a normal part of aging itself). b. Major Depressive Disorder (MDD, a serious mood disorder causing persistent sadness, loss of interest, and impaired daily functioning). c. Personal history of other mental and behavioral disorders (a medical classification, that indicates a patient has a history of past mental health issues). d. Anxiety (excessive worry, restlessness, rapid heart rate, trouble concentrating, and sleep issues). e. Dementia f. Restlessness and agitation (states of inner tension and inability to stay still). F. Record review of R #8's physician orders, multiple dates, revealed the following; 1. An order dated 10/20/25, for quetiapine fumarate (an atypical antipsychotic medication used to treat schizophrenia and bipolar disorder) 50 mg two times a day for agitation and anxiety. 2. An order dated 08/15/25, for Lasix (a prescription loop diuretic primarily used to treat fluid retention (edema) 10 mg once a day for edema (swelling from excess fluid trapped in body tissues). G. Record review of R #8's care plan, dated 09/17/25, revealed the following: 1. Staff did not document that R #8 was taking an antipsychotic medication or any interventions in place for monitoring. 2. Staff did not document that R #8 was taking a diuretic medication or any interventions in place for monitoring. H. On 12/12/25 at 2:35 PM, during an interview, the Regional Clinical Nurse (RCN) confirmed the following: 1. Staff did not revise R #8's care plan to include that she was taking the antipsychotic medication quetiapine fumarate or any interventions in place to monitor R #8 for side effects of antipsychotic medication. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. Staff did not revise R #8's care plan to include that she was taking the diuretic medication Lasix or any interventions in place to monitor R #8 for side effects of diuretic medication. 3. Staff were expected to revise resident care plans when they start taking antipsychotic or diuretic medications. R #17 I. Record review of R #17's admission record, no date, revealed R #7 was admitted to the facility on [DATE] with the following diagnoses: 1. Lack of coordination. 2. Unspecified abnormalities of gait and mobility. 3. Muscle weakness. J. Record review of R #17's physician order, dated 07/10/25, revealed an order for anti rollback device on R #17's wheelchair. K. Record review of R #17's care plan revealed the following: 1. On 09/22/25, R #17 would be evaluated for an anti-roll back lock for his wheelchair. The care plan does not document that R #17 had been evaluated and that the wheelchair lock had been installed on his wheelchair. The care plan does not document the interventions for the roll back lock. 2. On 02/25/25, R #17 had a painful tooth infection and R #17 would see a dentist. L. On 12/11/25 at 10:53 AM, during an interview with CNA #8, she stated R #17 did have an infection but that he had been to the dentist and that the infection was resolved. CNA #8 stated that the resident has a history of falls and that the rollback device was to assist the resident with transfers so that his wheelchair would lock and not roll away. M. On 12/11/25 at 11:24 AM, during an interview, the Social Services Coordinator stated that the resident went to the dentist on 03/25/25. N. On 12/11/25 at 12:19 PM, during an interview, the MDS Coordinator confirmed that R #17 does not currently have a tooth infection. The MDS Coordinator stated that the care plan should have been updated when infection resolved. O. On 12/11/25 at 1:23 PM, during an interview, the DON stated that resident care plans should be updated with the most current interventions (action, treatment, or procedure used to diagnose, prevent, manage, improve a health condition, or support overall well-being). The DON stated that if a diagnosis was resolved, the care plan should be updated. R #25 P. On 12/10/25 at 10:04 AM, during an observation and interview, the following was revealed: (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R #25 stated he doesn't like the pureed diet (smooth, moist, pudding-like foods that require no chewing, ideal for those with swallowing or chewing difficulties from surgery, illness, or conditions like dementia) and wants to see if it can be changed. R #25 stated he likes to snack on other foods such as cottage cheese, crackers and snack cakes. Two chocolate snack cakes were on R #25's bedside table. Q. Record review of R #25's admission Record (no date) revealed the following: 1. R #25 was admitted to the facility on [DATE]. 2. R #25 had a diagnosis of dysphagia (difficulty swallowing). R. Record review of R #25's physician's order revealed an order dated 10/06/25, for large portions diet puree texture (smooth and creamy substance made from blending food to a liquid consistency), thin consistency (liquid consistency that is not sticky and is easy to swallow). S. On 12/12/25 9:45 AM, during an interview with the dietitian, the following was revealed. 1. R #25's like to pick and choose what he eats, he only likes meat and desserts. 2. She confirmed that chocolate snack cakes are not the consistency of the diet that is ordered for R #25. T. Record review of R #25's care plan, revision (update) date 09/18/25, revealed staff did not document in the care plan that R #25 is noncompliant with his ordered diet. U. On 12/12/25 11:55 AM, during an interview, the RCN confirmed the following: 1. R #25's care plan did not include a revision to include that R #25 is not compliant with his ordered diet. 2. Her expectation is that the care plan would have a specific plan in place for his noncompliance and actions staff can't take to assist him. R #36 V. Record review of R #36's admission documents, no date, revealed the following: 1. R #36 was admitted to the facility on [DATE]. 2. R #36 had the following diagnoses: a. Psychotic disorder with delusions due to known physiological condition (involves firmly holding false beliefs (delusions) for at least a month, without prominent psychotic symptoms like hallucinations or disorganized speech). b. Major depressive disorder (MDD, a serious mood disorder causing persistent sadness, loss of (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	interest, and impaired functioning, marked by symptoms like sleep/appetite changes, fatigue, guilt, poor concentration, and suicidal thoughts). c. Anxiety disorder (serious mental illnesses marked by excessive, persistent fear and worry that disrupt daily life). W. Record review of R #36's physician's orders, multiple dates, revealed the following: 1. An order dated 11/05/25, for quetiapine fumarate 25 mg three times a day for psychosis (a state where a person loses touch with reality, experiencing symptoms like hallucinations (seeing/hearing things not there) or delusions (fixed false beliefs), alongside disorganized thinking, speech, and behavior, often with paranoia or confusion, and can stem from mental illnesses). 2. An order dated 11/22/25, for sertraline 50 mg once a day for depression. X. Record review of R #36's care plan, revised 09/22/25, revealed staff did not document R # 36's orders and antipsychotic and antidepressant medications, or any interventions in place to monitor these medications. Y. On 12/12/2025 at 2:32 PM, during an interview, the RCN confirmed the following: 1. Staff did not revise R #36's care plan to include that she was taking the antipsychotic medication quetiapine fumarate or any interventions in place to monitor R #36 for side effects of antipsychotic medication. 2. Staff did not revise R #36's care plan to include that she was taking the antidepressant medication sertraline or any interventions in place to monitor R #36 for side effects of antidepressant medication. 3. Staff were expected to revise resident care plans when they start taking antipsychotic or antidepressant medications.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interviews, the facility failed to meet professional standards of practice (established guidelines and expectations that ensure the delivery of high-quality care to residents) for 2 (R #5 and R #17) of 7 (R #5, R #6, R #7, R #17, R #36, R #69 and R #76) residents reviewed for neglect when staff failed to follow physician orders. If the facility is not providing care per physician's orders, and providing care that meets professional standards of practice, then residents are likely to experience adverse effects, worsening of their condition, and potential complications from not receiving the care ordered by the physician. The findings are: R #5 A. Record review of R #5's admission record, no date, revealed the following: 1. R #5 was admitted to the facility on [DATE]. 2. R #5's diagnoses include the following: a. Diastolic (congestive) heart failure (heart's main pumping chamber (left ventricle) becomes stiff and can't relax properly to fill with enough blood between beats). b. Chronic atrial fibrillation, unspecified (long-term, irregular heart rhythm where the upper chambers quiver chaotically). c. Unspecified atrial fibrillation (the heart's upper chambers (atria) beat irregularly and often too fast due to chaotic electrical signals). d. Presence of a cardiac pacemaker (a small, battery-powered device implanted under the skin that regulates your heartbeat). e. Cardiomyopathy (chronic disease of the heart muscle). B. Record review of R #5's physician orders revealed an order dated 10/04/24 and discontinued 06/08/25 for amiodarone (a potent antiarrhythmic medication used to treat and prevent serious, life-threatening heart rhythm disorders) 200 mg one time a day, hold for blood pressure less than SBP (the top number in a blood pressure reading, representing the pressure in your arteries when your heart contracts (beats) and pushes blood out) 100, DBP (the pressure in your arteries when your heart rests and refills with blood between beats, representing the bottom, lower number in a blood pressure reading) less than 50 and pulse (a rhythmical throbbing of the arteries as blood is propelled through them) less than 60. C. Record review of R #5's MAR medication administration record (MAR; a form used to document medication administration), dated June 2025, revealed R #5's prescription amiodarone was documented as given every am from the 1st to the 8th. R #5's blood pressure was not documented. D. Record review of R #5's blood pressure summary for June 2025 revealed from the 1st until the 8th, R #5's blood pressure was only documented 4 times out of the 8 times the medication was given before the prescription was discontinued. E. Record review of R #5's MAR dated May 2025, revealed R #5's prescription amiodarone was documented as given every am. R #5's blood pressure was not documented. F. Record review of R #5's blood pressure summary for May 2025 revealed that out of the 31 days in May, R #5's blood pressure was only documented 4 times. G. Record review of R #5's MAR dated April 2025, revealed R #5's prescription amiodarone was documented as given every am. R #5's blood pressure was not documented. H. Record review of R #5's blood pressure summary for April 2025 revealed that out of the 30 days in April, R #5's blood pressure was only documented 5 times. I. On 12/11/25 at 6:28 PM, during an interview, the DON stated R #5's blood pressure should be checked every time staff administer amiodarone. J. On 12/12/25 at 8:59 AM, during an interview, the Regional Clinical Nurse (RCN) confirmed that staff were not documenting that they checked R #5's blood pressure before giving her amiodarone as per the order dated 10/24/25 to 06/08/25. The RCN stated that the expectation is that R #5's blood pressure should be taken and documented before her amiodarone is given. R #17 K. Record review of R #17's admission record, no date, revealed the following: 1. R #17 was admitted to the facility on [DATE]. 2. R #17's diagnosis of a contracture, left hand (tissues (skin, fascia, tendons) tighten, pulling one or more fingers into a bent position, often towards the palm, making them hard to straighten). L. Record review of R #17's (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	physicians order, dated 10/08/25, revealed splint ordered patient to wear left modified palm guard daily or as tolerated. M. On 12/11/25 at 9:19 AM, during an observation of the secured unit, revealed R #17 was not wearing a splint. N. On 12/11/25 at 9:22 AM, during an interview, CNA #9 stated she did not know that R #17 was supposed to wear a splint on his left hand. O. On 12/11/25 at 9:23 AM, during an interview, CNA #10 stated that she was told about the splint yesterday. She stated that she remembered seeing the resident wear a splint a while back, but that she had not seen the splint, or the resident wear the splint for a long time. CNA #10 stated that the splint used to be in the resident's drawer in his room but that she didn't know where it was anymore. P. On 12/11/25 at 9:31 AM, during an interview, the DON stated that she did not know anything about the order for R #17's splint. The DON stated that the order was discontinued yesterday (12/10/25). The DON stated that R #17 was not compliant with wearing the brace, so they discontinued the order. Q. Record review of R #17's care plan, dated 10/27/25, revealed no documentation that R #17 was not compliant with wearing the splint. R. On 12/11/25 at 9:46 AM, during an interview with the Director of Rehabilitation (DOR), she stated that the splint was ordered by an occupational therapist (OT). The DOR confirmed that the order was for R #17 to wear the splint daily or as tolerated. The DOR stated that the order was discontinued without consultation with the OT. The DOR stated that they should have been consulted with before the order was discontinued. S. On 12/11/25 at 10:25 AM, during an interview, the RCN confirmed that the order for R #17's splint was discontinued on 12/10/25. The RCN stated that hospice discontinued the order. The RCN stated that the occupational therapist should have been consulted prior to discontinuing the order.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. Based on observation, record review, and interview, the facility failed to ensure residents received treatment and care in accordance with professional standards of practice for 1 (R #6) of 2 (R #5 and R #6) residents when staff failed to: 1. Identify open wounds on R #6's lower legs. 2. Follow up on the burning sensation when R #6 urinated. These deficient practices could likely lead to residents needs not being met and/or a worsening of their condition. The findings are:A. On 12/10/25 at 10:10 AM, during an interview, R #6 stated he was in a lot of pain. He stated that it burned really bad when he urinated and that it was almost unbearable. R #6 also stated that his legs hurt really bad. R #6 further stated he had told staff but that nothing had been done about it. R #6 stated that he has told several staff that he was hurting for months. R #6 stated that he had been in pain for about 3 months. B. On 12/10/25 at 1:54 PM, during an observation of R #6's legs, revealed resident's lower legs were discolored and there were open wounds and scabbing on both legs. C. Record review of R #6's skin assessments revealed the following: 1. 11/08/25 did not document any skin impairments. 2. 11/16/25 no assessment was done. 3. 11/23/25 did not document wounds on R #6's lower legs. 4. 11/30/25 did not document wounds on R #6's lower legs. 5. 12/07/25 did not document any skin impairments. D. On 12/12/25 at 9:38 AM, during an interview and observation, the DON observed and confirmed that R #6 had open wounds on both of his lower legs and that she had not been made aware of the wounds. E. On 12/12/25 at 9:43 AM, during an interview, CNA #11 stated that she did know that R #6 had wounds on his lower legs. F. On 12/12/25 at 9:46 AM, during an interview, LPN #8 stated that she knew R #6 had wounds on his lower legs. LPN #8 stated that she had let the DON know that R #6 had wounds but doesn't remember when. LPN #8 confirmed that there is no documentation of the wounds on R #6's legs or that the provider and the DON were notified. G. On 12/12/25 at 10:15 AM, during an interview, ADON confirmed that she did R #6's skin assessment on 12/07/25. The ADON stated that when she does the skin assessments she is with the residents. The ADON confirmed that she did not document any wounds on R #6's lower legs on 12/07/25. The ADON stated she doesn't remember seeing any wounds on R #6's legs. The ADON stated that she is not aware of any wounds that R #6 has on his legs. H. On 12/12/25 at 10:16 AM, during an observation of R #6's legs, the ADON confirmed that R #6 does have wounds on both legs. I. On 12/12/25 at 11:05 AM, during an interview, LPN #9 stated that she usually does R #6's skin assessments. LPN #9 stated that she was aware of a wound on R #6's hand, but that she had not seen any wounds on the resident's legs. J. Record review of R #6's medical record, no date, revealed that there was no documentation that R #6 was having pain while he urinated. There was no documentation that the provider was notified of R #6's pain during urination. K. On 12/12/25 at 11:09 AM, during an interview, LPN #9 stated that R #6 had told her that it was burning down there. LPN #9 stated that she asked R #6 to clarify where it was hurting and that R #6 stated he couldn't feel it. LPN #9 stated she was confused and could not figure out what R #6 was saying or where it hurt. LPN #9 stated that she isn't sure if she notified the provider. LPN #9 stated did not document that R #6 was complaining of pain. L. On 12/12/25 at 1:06 PM, during an interview, R #6 stated to the surveyor and ADON that he was in a lot of pain. R #6 stated that his legs were hurting and that it burned when he urinated. M. On 12/12/25 at 3:25 PM, during an interview, the Regional Clinical Nurse (RCN) stated that the sores on R #6's legs should have been identified and that the provider should have been made aware of the sores. The RCN stated that if R #6 was complaining of pain while urination, that the provider should have been notified and that a urinalysis should have been done.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observation, and interview, the facility failed to ensure appropriate treatment for urinary conditions (conditions affect the kidneys, bladder, and tubes connecting them, ranging from common issues like Urinary Tract Infections (UTIs), incontinence, and kidney stones to more complex problems like overactive bladder, interstitial cystitis, and prostate issues (in men) for 1 (R #2) of 4 (R #2, R #5, R #6, and R #76) resident's reviewed for urinary conditions, when staff failed to provide services for Foley Catheter tubing (soft plastic or rubber tube that is inserted to the bladder to drain the urine and is connected to a collecting bag) care for R #2.This deficient practice could result in residents being susceptible to worsening of infection or becoming septic (potentially life-threatening when the body responds to infection by damaging its own tissues) The findings are: A. Record review of R #2's admission documents, no date, revealed the following: 1. R #2 was admitted to the facility on [DATE]. 2. R #2 had the following diagnoses: a. Infection and inflammatory reaction due to indwelling ureteral stent (infection or swelling due to a thin, flexible tube placed in the ureter (the tube from kidney to bladder) to keep it open, allowing urine to flow past blockages like kidney stones or after surgery, often causing symptoms like frequent urination, burning, urgency, or blood in urine). b. Calculus of kidney (a hard deposit of minerals and salts (like calcium, oxalate, uric acid) that forms in the kidneys when urine becomes too concentrated). c. Calculus of ureter (a kidney stone that has moved into the ureter, the tube connecting the kidney to the bladder, causing severe, colicky pain (renal colic) in the flank, abdomen, and groin, often with nausea, vomiting, and blood in the urine). d. Obstructive and reflux uropathy (blocks urine flow, causing backup (hydronephrosis) and potential kidney damage, while vesicoureteral reflux (VUR: a type of obstructive uropathy) is urine flowing backward from bladder to kidneys, often due to faulty valves). B. Record review of R #2's physician order, dated 08/23/25, revealed the following: 1. An order completed on 09/09/25 (order was incorrectly entered and automatically discontinued on 09/09/25), to change foley catheter (a thin, flexible tube inserted into the bladder through the urethra to drain urine) every 30 days. 2. An order for foley catheter care (strict hygiene, cleaning the insertion site daily with soap and water, keeping the drainage bag below bladder level, ensuring tubing is free of kinks, and staying hydrated to prevent urinary tract infections (UTIs) and blockages, always washing hands before and after handling to reduce germ spread) every shift. 3. An order to change foley catheter as needed for leakage or drainage. 4. An order to irrigate (the process of injecting a sterile solution (like saline) into the catheter tube to clear blockages from mucus, blood clots, or debris, ensuring it stays open and drains properly, preventing complications) catheter as needed. C. Record review of R #2's MAR, dated September 2025, revealed on 09/08/25, staff documented that R #2 refused for his catheter to be changed. D. Record review of R #2's MAR, dated October 2025, revealed on 10/22/25, staff documented that they changed his foley catheter. E. Record review of R #2's MAR, dated November 2025, revealed staff did not document changing R #2's foley catheter. F. Record review of R #2's MAR, dated December 2025, revealed staff did not document changing R #2's foley catheter. G. On 12/12/25 at 9:05 AM, during an interview with LPN #16, she stated the following: 1. Typically, resident's foley catheters should be changed out every 30 days. 2. R #2's order for foley catheter change every 30 days was incorrectly entered and incorrectly discontinued on 09/09/25. 3. R #2's foley catheter was only changed once since 08/23/25. H. On 12/12/25 9:10 AM, during an interview, the ADON confirmed the following: 1. Foley catheters should be changed every 30 days unless there is an order for something different. 2. R #2's order (continued on next page)

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	325073	A. Building B. Wing	12/16/2025

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	for foley catheter change every 30 days was incorrectly entered so it discontinued on 09/09/25. 3. R #2's foley catheter was only changed once on 10/22/25. 4. Staff were expected to ensure resident's foley catheters were changed as ordered.

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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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to follow professional standards of practice for oxygen therapy for 3 (R #7, R #69, and R #76) of 3 (R #7, R #69, and R #76) residents reviewed for respiratory care, when staff failed to: 1. Ensure residents wore their oxygen continuously for R #7 and R #76. 2. Ensure oxygen concentration was administered per physician's order for R #69. 3. Document respiratory assessments (a systematic evaluation of breathing, using inspection, palpation, percussion, and auscultation to check vital signs, observe breathing patterns, feel the chest, tap for sounds, and listen with a stethoscope for lung sounds and chest movement) for R #69. If the facility is not assessing respiratory status and following orders for oxygen use then the resident may be low on oxygen, which could potentially cause health concerns such as shortness of breath, confusion, rapid heart rate, fatigue, and blue skin (cyanosis). The findings are:R #7 A. Record review of R #7's admission documents, no date, revealed the following: 1. R #7 was admitted to the facility on [DATE]. 2. R #7 had the following diagnoses: a. Chronic respiratory failure with hypoxia (lungs consistently can't get enough oxygen into the blood). b. Simple chronic bronchitis (a condition causing a persistent, mucus-producing cough for months, often linked to smoking or irritant exposure). B. Record review of R #7's physician's orders, multiple dates, revealed an order dated 08/21/24, for oxygen via nasal cannula (a simple, common medical device with two soft prongs that fit into the nostrils, delivering supplemental oxygen or increased airflow from a supply source (like an oxygen concentrator) through a tube) at one (1) to two (2) liters per minute (LPM, flow rate of oxygen). C. On 12/10/25 at 10:23 AM, during an interview and observation of R #7 in his room, the following was revealed: 1. R #7 was sitting in his wheelchair next to his bed. 2. R #7 was observed not wearing a nasal cannula and his oxygen concentrator (a medical device that provides concentrated oxygen to people with breathing problems by taking in ambient air, removing nitrogen and impurities, and delivering purified, oxygen-enriched air through a nasal cannula or mask) was turned off. 3. R #7 stated he only wears his oxygen at night and if he needs it during the day. D. On 12/11/25 at 2:08 PM, during an observation of R #7 in the dining area, he was observed not wearing a nasal cannula and he did not have a portable oxygen concentrator with him. E. On 12/11/25 at 2:47 PM, during an interview with LPN #16, she stated R #7 only wears his oxygen at night and if his oxygen gets below 90% during the day. F. On 12/11/25 at 2:54 PM, during an interview, the ADON confirmed the following: 1. R #7 uses oxygen at night and as needed during the day. 2. R #7's physicians order was for R #7 to wear his oxygen continuously at one (1) to two (2) LPM. 3. Staff were expected to ensure residents wear oxygen as ordered and notify the provider if there is a change in the residents' condition that indicates the order may need to be changed. R #69 G. Record review of R #69's admission documents, no date, revealed the following: 1. R #69 was admitted to the facility on [DATE]. 2. R #69 had the following diagnoses: a. Chronic Obstructive Pulmonary Disease (COPD) a progressive lung disease making breathing difficult). b. Chronic respiratory failure with hypoxia. c. Solitary pulmonary nodule (a small, round spot in the lung). d. Dependence on supplemental oxygen (body needs extra oxygen to keep organs healthy due to low blood oxygen (hypoxemia), often from lung diseases like COPD). H. Record review of R #69's hospice admission orders, dated 11/12/25, revealed an order for oxygen via nasal cannula at eight (8) to ten (10) LPM. I. Record review of R #69's physician's order, dated 11/13/25, revealed the following: 1. An order for Albuterol-Budesonide Inhalation Aerosol (is a dual-action prescription medication used as a rescue inhaler for adults with asthma) give two (2) puffs every four (4) hours as needed for shortness of breath (SOB). 2. An order for oxygen via nasal cannula at a rate of six (6) to eight (8) LPM for COPD (did not (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	match order from hospice for eight (8) to ten (10) LPM). 3. An order to raise the head of the bed or provide a pillow while resident was in bed for shortness of breath due to COPD. 4. An order to change oxygen tubing and oxygen concentrator filter every week. J. Record review of R #69's progress notes, multiple dates, revealed the following: 1. On 11/20/25, staff documented that R #69 had his oxygen concentrator at 10 LPM and staff educated him that oxygen concentrator should be at eight (8) to ten (10) LPM, but resident refused. Staff did not document that a provider was notified. Staff did not document an assessment of R #69's respiratory status. 2. On 11/26/25, staff documented that R #69's oxygen concentrator was decreased to 15 LPM (outside the ordered range of 6-8 LPM, staff did not document how high the oxygen concentrator was at before it was decreased). Staff documented that resident was calmer than before and didn't have sputum production (the body's way of creating mucus in the lower airways (bronchi/bronchioles) to trap particles, which is then coughed up) or nasal drainage (excess mucus from the nose, often caused by colds, flu, allergies, or irritants). Staff documented that they notified hospice staff and that the hospice nurse would come to see R #69. Staff did not document an assessment of R #69's respiratory status other than oxygen saturation (the percentage of oxygen carried in red blood cells, normally 95-100% in healthy people). 3. On 11/28/25, staff documented that R #69 had an episode of shortness of breath and his oxygen saturation dropped to 42%. Staff gave ordered albuterol and medications to decrease R #69's anxiety and his oxygen increased to 93% on 14 LPM of oxygen (outside the ordered range of 6-8 LPM). Staff did not document an assessment of R #69's respiratory status. Staff did not document that a provider was notified regarding R #69's episode of shortness of breath or that he was using 14 LPM of oxygen. K. On 12/11/25 at 9:02 AM, during an interview, LPN #16 stated the following: 1. When there is a concern with a resident who was on hospice, they call the hospice number and speak with the nurse. The nurse will notify the hospice provider and call them back with any changes in orders. 2. She notified the hospice nurse any time R #69 had respiratory issues. 3. R #69 had an order for oxygen at a rate of 6-8 LPM. 4. R #69 would turn up his own oxygen, and they would educate him that he needed to keep it at the ordered rate. 5. She was not aware that hospice had ordered for R #69's oxygen to be at a rate of 8-10 LPM. 6. R #69 usually had his oxygen at 10 LPM. 7. She assessed R #69's lung sounds but never documented a respiratory assessment for R #69. L. On 12/11/25 at 11:51 AM, during an interview, the ADON confirmed the following: 1. Staff were expected to assess resident respiratory status at least every shift and document it in the medical record. 2. R #69's order in his medical record was for 6-8 LPM and the admitting orders from hospice was for 8-10 LPM. 3. Staff were expected to ensure the orders in the medical record matched the admitting orders that were received from hospice. 4. If a resident was needing a higher oxygen concentration, staff were expected to notify the provider and enter orders according to the providers response. R #76 M. Record review of R #76's admission documents, no date, revealed the following: 1. R #76 was admitted to the facility on [DATE]. 2. R #76 had a diagnosis of chronic respiratory failure (a long-term condition where the lungs can't effectively get enough oxygen into the blood or remove enough carbon dioxide, leading to gradual symptoms like shortness of breath, fatigue, confusion, and a bluish tint to skin or nails). N. Record review of R #76's admission orders, dated 12/05/25, for continuous oxygen starting at two (2) LPM and increase to keep oxygen greater than 90%. O. Record review of R #76's physician's order, dated 12/05/25, revealed an order to increase oxygen requirement by two (2) LPM to keep oxygen saturations greater than 90% (did not match admission order to start at two (2) LPM). P. On 12/10/25 at 9:05 AM, during an observation of R #76 in her room, revealed the following: 1. R #76 was lying in her bed. 2. R #76 was wearing a nasal cannula. 3. R #76's oxygen concentrator was set at three (3) LPM. Q. On 12/11/25 at 1:49 PM, during an (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	interview and observation of R #76 in her room, revealed the following: 1. R #76 was lying in her bed. 2. R #76's nasal cannula was laying on her oxygen concentrator. 3. R #76's oxygen concentrator was off. 4. R #76 stated that staff had put her to bed after lunch and forgot to put her oxygen on her. R. On 12/11/25 at 1:51 PM, during an interview, LPN #16 stated the following: 1. R #76 should always wear her nasal cannula. 2. R #76's oxygen concentrator was usually set at 3 LPM. 3. R #76's had a physician's order for oxygen to start at two (2) LPM and increase oxygen till R #76's oxygen saturation was above 90%. 4. She confirmed that R #76 was not wearing her nasal cannula and should have been. S. On 12/12/25 at 3:14 PM, during an interview, the Regional Clinical Nurse (RCN) confirmed the following: 1. R #76's order was entered incorrectly and stated to increase oxygen requirement by two (2) LPM until oxygen saturation was above 90%. 2. R #76's physician's order should have said that R #76's oxygen concentrator should start at two (2) LPM and increase to keep oxygen saturation above 90%. 3. Residents should wear their oxygen as ordered unless they refuse. 4. If a resident refuses to wear oxygen, staff should notify the physician and document the physician's response.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	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 interview, the facility failed to properly store medications, which could affect all 59 residents in the facility (Residents were identified by the resident matrix provided by the ADON on 12/09/25), when they failed to: 1. Ensure medications were not expired in the medication room. 2. Ensure medications were not expired in the electronic medication management dispensing machine. This deficient practice could likely result in residents obtaining medications that are no longer effective, resulting in adverse side effects. The findings are: A. On 12/11/25 at 11:32 AM, during an observation of the medication room, revealed the following: 1. Medication Storage Cabinets a. One (1) bottle of Daily Multivitamin tablets with an expiration date of 08/2025. b. One (1) bottle of Daily Multivitamin tablets with an expiration date of 11/2025. c. One (1) bottle of Ibuprofen (pain reliever) 200 mg tablets with an expiration date of 09/2025. 2. Electronic medication dispensing machine a. One (1) tablet of amlodipine (medication used to treat high blood pressure) 5 mg with an expiration date of 12/02/25. b. Two (2) tablets of sertraline (antidepressant medication) 25 mg with an expiration date of 11/27/25. B. On 12/11/25 at 11:40 AM, during an interview, the ADON confirmed the following: 1. There were two (2) bottles of Daily Multivitamin tablets that were expired in the medication storage cabinets. 2. There was one (1) bottle of Ibuprofen tablets that was expired in the medication storage cabinets. 3. There was one (1) tablet of amlodipine 5 mg that was expired in the electronic medication dispensing machine. 4. There were two (2) tablets of sertraline 25 mg that were expired in the electronic medication dispensing machine. 5. Staff were expected to remove expired medications from the medication cabinets and the electronic dispensing machine.

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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 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide or obtain dental services for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observation, and interview the facility failed to ensure residents obtained dental services for 4 (R #6, R #7, R #36, and R #60) of 8 (R #4, R #5, R #6, R #7, R #10, R #17, R #36, and R #60) residents sampled for dental services, when staff failed to: 1. Schedule a follow up visit for R #6. 2. Schedule routine annual dental services for R #7 and R #60. 3. Schedule dental services for R #7's broken tooth. 4. Schedule dental services after R #36 lost her dentures. This deficient practice is likely to cause the resident unnecessary pain, embarrassment over the condition/appearance of teeth, and potential dental or oral complications. R #6 A. Record review of R #6's admission record, no date, revealed R #6 was admitted to the facility on [DATE]. B. On 12/10/25 at 10:05 AM, during an interview, R #6 stated that he has problems with his teeth. R #6 stated he was supposed to go the dentist, but that staff has not made an appointment for him. C. On 12/12/25 at 10:27 AM, during an interview with the Social Services Coordinator (SSC), she stated that R #6 had a dentist appointment on 07/25/25. SSC stated that there was a follow up appointment scheduled for 07/28/25, but the R #6 refused to go. The SSC stated that a follow up appointment has not been rescheduled for R #6. R #7 D. Record review of R #7's admission documents, no date, revealed R #7 was admitted to the facility on [DATE]. E. On 12/10/25 at 10:14 AM, during an interview and observation of R #7 in his room, revealed the following: 1. R #7 stated his bottom right front tooth broke a couple of months ago. 2. R #7 told one of the staff about his broken tooth and they said they would send him to the dentist. 3. R #7 had a broken tooth on the bottom front right side of his mouth. 4. R #7 said he did not remember the last time that he had seen the dentist. F. On 12/12/25 at 10:52 AM, during an interview, LPN # 16 stated the following: 1. She was not aware that R #7 had a broken tooth. 2. Staff are supposed to notify the social services coordinator for any dental needs so she can make the resident an appointment. G. On 12/12/25 at 11:08 AM, during an interview, the Social Services Coordinator (SSC) confirmed (continued on next page)

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	the following: 1. She was not aware that R #7 had a broken tooth. 2. R #7 did not have an appointment scheduled to see the dentist for his broken tooth. 3. Staff were expected to notify her if anyone had emergent dental needs so she could schedule a dental appointment. 4. She did not know the last time R #7 had seen a dentist. 5. She was not aware that residents were supposed to be scheduled at least annually for routine dental appointments. R #36 H. Record review of R #36's admission documents, no date, revealed R #36 was admitted to the facility on [DATE]. I. On 12/10/25 at 9:59 AM, during an interview, R #36's family member (FM) stated the following: 1. R #36 had top dentures when she was admitted to the facility. 2. R #36 had lost her bottom dentures prior to being admitted to the facility. 3. R #36 had not been seen by the dentist since she was admitted to the facility. J. On 12/12/25 at 9:43 AM, during an observation and interview of R #36, revealed the following: 1. R #36 stated she did not have any teeth or dentures. 2. R #36 stated she had dentures, but she was not sure what happened to them. 3. R #36 did not have any of her own teeth and she was not wearing dentures. K. On 12/12/25 at 11:01 AM, during an interview, the SSC stated the following: 1. She was not aware that R #36 was missing her dentures. 2. She had not made an appointment for R #36 to see the dentist for dentures. L. On 12/12/25 at 11:15 AM, during an interview, the Regional Clinical Nurse confirmed the following: 1. Staff are expected to notify the SSC when a resident has any dental needs so she can schedule an appointment for the resident. 2. The SSC is expected to offer to schedule routine dental appointments annually for the residents. (continued on next page)

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R #60 M. Record review of R #60's admission record, no date, revealed R #60 was admitted to the facility on [DATE]. N. On 12/10/25 at 11:56 AM, during an interview, R #60's Power of Attorney (POA a person that has the legal authority to act on the behalf of another person) stated R #60 had not been to the dentist. R #60's POA did not know how long it had been but stated she thought it had been years. O. Record review of R #60's medical record, no date, revealed no documentation of R #60 going to the dentist for routine dental care. P. On 12/12/25 at 10:35 AM, during an interview, the SSC confirmed that she had not scheduled R #60 for a routine dental appointment.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, and interview, the facility failed to ensure medical records were complete and accurate for 3 (R #7, R #69, and R #76) of 3 (R #7, R #69, and R 76) residents reviewed for respiratory treatment when staff failed to: 1. Document oxygen concentrator (a medical device that provides concentrated oxygen to people with breathing problems by taking in ambient air, removing nitrogen and impurities, and delivering purified, oxygen-enriched air through a nasal cannula or mask) rates for residents requiring oxygen for R #7, R #69, and R #76. 2. Ensure resident's orders entered in the computer matched the admitting orders for R #69 and R #76. These deficient practices have the potential to negatively impact the care staff provide to meet residents' needs due to missing or inaccurate records and resident information. The findings are: R #7 A. Record review of R #7's admission documents, no date, revealed the following: 1. R #7 was admitted to the facility on [DATE]. 2. R #7 had the following diagnoses: a. Chronic respiratory failure with hypoxia (lungs consistently can't get enough oxygen into the blood). b. Simple chronic bronchitis (a condition causing a persistent, mucus-producing cough for months, often linked to smoking or irritant exposure). B. Record review of R #7's physician's orders, multiple dates, revealed an order dated 08/21/24, for oxygen via nasal cannula (a simple, common medical device with two soft prongs that fit into the nostrils, delivering supplemental oxygen or increased airflow from a supply source (like an oxygen concentrator) through a tube) at one (1) to two (2) liters per minute (LPM, flow rate of oxygen). C. Record review of R #7's oxygen saturation documentation, dated 12/02/25 to 12/11/25, revealed the following: 1. On 12/02/25 at 9:11 PM, staff documented R #7's oxygen saturation (amount of oxygen carried by red blood cells) was 91%, and R #7 was using a nasal cannula. Staff did not document the oxygen concentrator rate. 2. On 12/03/25 at 7:23 PM, staff documented R #7's oxygen saturation was 93%, and R #7 was using a nasal cannula. Staff did not document the oxygen concentrator rate. 3. On 12/04/25 at 8:28 AM, staff documented R #7's oxygen saturation was 94%, and R #7 was using a nasal cannula. Staff did not document the oxygen concentrator rate. 4. On 12/04/25 at 7:33 PM, staff documented R #7's oxygen saturation was 93%, and R #7 was using a nasal cannula. Staff did not document the oxygen concentrator rate. 5. On 12/05/25 at 7:41 PM, staff documented R #7's oxygen saturation was 93%, and R #7 was using a nasal cannula. Staff did not document the oxygen concentrator rate. 6. On 12/06/25 at 8:27 AM, staff documented R #7's oxygen saturation was 94%, and R #7 was using a nasal cannula. Staff did not document the oxygen concentrator rate. 7. On 12/06/25 at 8:11 PM, staff documented R #7's oxygen saturation was 94%, and R #7 was using a nasal cannula. Staff did not document the oxygen concentrator rate. 8. On 12/07/25 at 10:57 PM, staff documented R #7's oxygen saturation was 95%, and R #7 was using a nasal cannula. Staff did not document the oxygen concentrator rate. 9. On 12/08/25 at 8:58 AM, staff documented R #7's oxygen saturation was 94%, and R #7 was using a nasal cannula. Staff did not document the oxygen concentrator rate. 10. On 12/09/25 at 1:06 AM, staff documented R #7's oxygen saturation was 93%, and R #7 was using a nasal cannula. Staff did not document the oxygen concentrator rate. 11. On 12/09/25 at 11:47 PM, staff documented R #7's oxygen saturation was 94%, and R #7 was using a nasal cannula. Staff did not document the oxygen concentrator rate. 12. On 12/10/25 at 8:44 AM, staff documented R #7's oxygen saturation was 93%, and R #7 was using a nasal cannula. Staff did not document the oxygen concentrator rate. 13. On 12/10/25 at 9:03 PM, staff documented R #7's oxygen saturation was 95%, and R #7 was using a nasal cannula. Staff did not document the oxygen concentrator rate. R #69 D. Record review of R #69's admission documents, no date, revealed the following: 1. R #69 was admitted to the facility on [DATE]. 2. R #69 had the (continued on next page)

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	325073	A. Building B. Wing	12/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Socorro Wellness & Rehabilitation	1203 Highway 60 West Socorro, NM 87801

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	following diagnoses: a. Chronic Obstructive Pulmonary Disease (COPD) a progressive lung disease making breathing difficult). b. Chronic respiratory failure with hypoxia (a long-term condition where the lungs can't supply enough oxygen to the blood). c. Solitary pulmonary nodule (a small, round spot in the lung). d. Dependence on supplemental oxygen (body needs extra oxygen to keep organs healthy due to low blood oxygen (hypoxemia), often from lung diseases like COPD). E. Record review of R #69's hospice admission orders, dated 11/12/25, revealed an order for oxygen via nasal cannula at eight (8) to ten (10) LPM. F. Record review of R #69's physician order, dated 11/13/25, revealed an order for oxygen via nasal cannula at a rate of six (6) to eight (8) LPM for COPD (did not match hospice admission orders). G. Record review of R #7's oxygen saturation documentation, dated 11/17/25 to 11/30/25, revealed the following: 1. On 11/24/25 at 12:34 PM, staff documented R #69's oxygen saturation was 90%, and R #69 was using a nasal cannula. Staff did not document the oxygen concentrator rate. 2. On 11/24/25 at 10:31 PM, staff documented R #69's oxygen saturation was 90%, and R #69 was using a nasal cannula. Staff did not document the oxygen concentrator rate. 3. On 11/25/25 at 8:27 AM, staff documented R #69's oxygen saturation was 90%, and R #69 was using a nasal cannula. Staff did not document the oxygen concentrator rate. 4. On 11/26/25 at 12:44 AM, staff documented R #69's oxygen saturation was 93%, and R #69 was using a nasal cannula. Staff did not document the oxygen concentrator rate. 5. On 11/26/25 at 7:49 AM, staff documented R #69's oxygen saturation was 79%, and R #69 was using a nasal cannula. Staff did not document the oxygen concentrator rate. 6. On 11/26/25 at 12:36 PM, staff documented R #69's oxygen saturation was 80%, and R #69 was using a nasal cannula. Staff did not document the oxygen concentrator rate. 7. On 11/27/25 at 7:37 AM, staff documented R #69's oxygen saturation was 89%, and R #69 was using a nasal cannula. Staff did not document the oxygen concentrator rate. 8. On 11/27/25 at 9:10 AM, staff documented R #69's oxygen saturation was 95%, and R #69 was using a nasal cannula. Staff did not document the oxygen concentrator rate. 9. On 11/24725 at 11:41 PM, staff documented R #69's oxygen saturation was 97%, and R #69 was using a nasal cannula. Staff did not document the oxygen concentrator rate. 10. On 11/28/25 at 8:45 AM, staff documented R #69's oxygen saturation was 93%, and R #69 was using a nasal cannula. Staff did not document the oxygen concentrator rate. 11. On 11/28/25 at 9:08 PM, staff documented R #69's oxygen saturation was 91%, and R #69 was using a nasal cannula. Staff did not document the oxygen concentrator rate. 12. On 11/29/25 at 12:35 AM, staff documented R #69's oxygen saturation was 93%, and R #69 was using a nasal cannula. Staff did not document the oxygen concentrator rate. 13. On 11/29/25 at 7:47 AM, staff documented R #69's oxygen saturation was 92%, and R #69 was using a nasal cannula. Staff did not document the oxygen concentrator rate. 14. On 11/29/25 at 8:50, staff documented R #69's oxygen saturation was 93%, and R #69 was using a nasal cannula. Staff did not document the oxygen concentrator rate. 15. On 11/30/25 at 8:51 AM, staff documented R #69's oxygen saturation was 85%, and R #69 was using a nasal cannula. Staff did not document the oxygen concentrator rate. R #76 H. Record review of R #76's admission documents, no date, revealed the following: 1. R #76 was admitted to the facility on [DATE]. 2. R #76 had a diagnosis of chronic respiratory failure. I. Record review of R #76's admission orders, dated 12/05/25, for continuous oxygen starting at two (2) LPM and increase to keep oxygen greater than 90%. J. Record review of R #76's physician's order, dated 12/05/25, revealed an order to increase oxygen requirement by two (2) LPM to keep oxygen saturations greater than 90% (did not match admission order to start at two (2) LPM). K. Record review of R #76's oxygen saturation documentation, dated 12/05/25 to 12/11/25, revealed the following: 1. On 12/06/25 at 8:51 AM, staff documented R #76's oxygen saturation was 94%, and R #76 was using a nasal cannula. Staff did not document the oxygen concentrator rate. 2. On 12/08/25 at 9:65 AM, staff documented R #76's oxygen (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	saturation was 90%, and R #76 was using a nasal cannula. Staff did not document the oxygen concentrator rate. 3. On 12/09/25 at 9:05 AM, staff documented R #76's oxygen saturation was 91%, and R #76 was using a nasal cannula. Staff did not document the oxygen concentrator rate. 4. On 12/10/25 at 8:49 AM, staff documented R #76's oxygen saturation was 90%, and R #76 was using a nasal cannula. Staff did not document the oxygen concentrator rate. 5. On 12/11/25 at 8:43 AM, staff documented R #76's oxygen saturation was 96%, and R #76 was using a nasal cannula. Staff did not document the oxygen concentrator rate. L. On 12/11/2025 at 2:54 PM, during an interview, the ADON confirmed the following: 1. R #69's hospice admission orders and the orders entered in R #69's medical record did not match. 2. R #76's admission orders and the orders entered in R #76's medical record didn't match. 3. Staff were expected to ensure orders were entered into the medical record correctly and if they had questions, they should contact the provider to verify. 4. Staff did not document oxygen concentrator rates for R #7, R #69, and R #76 when they documented oxygen saturations. 5. Staff were expected to document oxygen concentrator rates when they documented oxygen saturations in the medical record.

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure hospice services met professional standards for 2 (R #8 and R 69) of 2 (R #8 and R #69) residents reviewed for hospice services when staff failed to: 1. Ensure resident medical records had relevant communication indicating the delivery of hospice services (services provided for a person experiencing an advanced, life-limiting illness) for R #8 and R #69. 2. Ensure there was a coordinated plan of care in R #8's medical record delineating services that hospice was responsible for and services the facility was responsible for. These deficient practices could likely lead to residents not receiving the services needed due to lack of collaboration and communication between the facility and hospice provider. The findings are: R #8 A. Record review of R #8's admission documents, no date, revealed the following: 1. R #8 was admitted to the facility on [DATE]. 2. R #8 had a diagnosis of senile degeneration of brain (an outdated term for age-related cognitive decline, now called dementia, a progressive loss of brain function due to damaged brain cells, most commonly from Alzheimer's, vascular issues, or Lewy body disease, causing memory loss, confusion, and impaired thinking, rather than being a normal part of aging itself). B. Record review of R #8's physician's order, dated 09/08/25, revealed an order for R #8 to be admitted to hospice services. C. Record review of R #8's entire medical record, no date, revealed the following: 1. R #8's medical record did not have any documentation from the hospice staff regarding services that were provided to R #8. 2. R #8's medical record did not have a coordinated plan of care delineating services that hospice was responsible for and services the facility was responsible for. D. Record review of the hospice binder (binder in the nurses' station for hospice documentation), no date, revealed the following: 1. There was no documentation in the binder for R #8's hospice services provided. 2. There was no documentation of a coordinated care plan delineating services that hospice was responsible for and services the facility was responsible for. E. On 12/11/25 at 4:05 PM, during an interview, LPN #16 stated the following: 1. R #8's hospice provider did not provide the facility with documentation regarding the services they provide. 2. She had not seen a coordinated care plan delineating services that hospice was responsible for and services the facility was responsible for R #8. 3. She was unsure which days hospice staff were expected to see R #8. 4. She was unsure what services hospice staff were supposed to provide for R #8, and which services were supposed to be provided by facility staff. F. On 12/11/25 at 4:38 PM, during an interview, the ADON confirmed the following: 1. Documentation from hospice providers should be available to staff in the hospice binder. 2. There was no documentation in the hospice binder or in R #8's medical record regarding services that were provided by R #8's hospice provider. 3. There was no coordinated care plan in the hospice binder or in R #8's medical record delineating services that hospice was responsible for and services the facility was responsible for. 4. R #8's hospice provider does not provide the facility with documentation regarding the services that they provide to residents receiving hospice services. R #69 G. Record review of R #69's admission documents, no date, revealed the following: 1. R #69 was admitted to the facility on [DATE]. 2. R #69 had a diagnosis of Chronic Obstructive Pulmonary Disease (COPD), a progressive lung disease making breathing difficult). H. Record review of R #69's orders, dated 11/13/25, revealed an order to admit R #69 for hospice services. I. Record review of R #69's entire medical record, no date, revealed R #8's medical record did not have documentation from the hospice staff regarding services that were provided to R #69. J. On 12/11/25 at 11:51 AM, during an interview, the ADON confirmed the following: 1. R #69's hospice provider does not provide documentation regarding care that was provided by hospice staff. 2. If the (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	hospice staff do not talk to the facility staff, they will not know what services were provided for the residents. 3. Staff do not have any documentation to look at to determine what services the hospice staff provided. ? 4. Hospice staff are expected to give documentation to the facility regarding the services that were provided to residents. 5. The medical records clerk is expected to scan any documentation into resident medical records that hospice staff provide. 6. R #69's medical record did not contain any documentation regarding services provided by the hospice staff. K. On 12/11/25 at 3:29 PM, during an interview, the medical records clerk confirmed the following: 1. The hospice provider did not provide any documentation regarding care provided to R #8 and R #69. 2. R #8 and R #69's hospice provider did not provide documentation to the facility. 3. Hospice providers were expected to provide visit notes after each visit so she could scan them in the resident medical record, and a copy should be kept in the hospice binder at the nurse's station. L. On 12/11/25 at 4:40 PM, during an interview, the Regional Clinical Nurse (RCN) confirmed the following: 1. Each hospice resident should have a coordinated care plan delineating services that hospice was responsible for and services the facility was responsible for. 2. Staff should know where to locate the coordinated care plan. 3. Hospice staff are expected to provide the facility with documentation every time they visit a resident.

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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 0851 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Electronically submit to CMS complete and accurate direct care staffing information, based on payroll and other verifiable and auditable data. Based on record review and interview, the facility failed to submit direct care staffing information to the federal agency overseeing certification for long term care facilities for Quarter #4 (July 1, 2024-September 30, 2024). This has the potential to affect all 59 residents in the facility, (residents were identified by the Resident Matrix provided by the ADON on (12/08/25). This deficient practice could likely result in inaccurate direct care staffing information for residents/facility. The findings are:A. Record review of Payroll Base Journal (PBJ) Staffing Data Report (report from the database of the federal agency overseeing certification for long term care facilities) dated Quarter #4 (July 1, 2024-September 30, 2024), revealed no licensed nursing coverage for 24 hours/day for the following dates: 1. 07/14/24, 2. 08/4/24, 3. 08/11/24, 4. 08/18/24, 5. 08/25/24, 6. 09/1/24, 7. 09/8/24, 8. 09/13/24, 9. 09/14/24, 10. 09/15/24, 11. 09/21/24, 12. 09/22/24, 13. 09/28/24. B. On 12/12/2025 at12:47 PM, during an interview with Regional Director, he stated that this company took over on 11/01/25 and was unable to obtain clock ins and outs for nursing staff from previous ownership for Quarter #4 for the following dates (July 1, 2024-September 30, 2024): 1. 07/14/24, 2. 08/4/24, 3. 08/11/24, 4. 08/18/24, 5. 08/25/24, 6. 09/1/24, 7. 09/8/24, 8. 09/13/24, 9. 09/14/24, 10. 09/15/24, 11. 09/21/24, 12. 09/22/24, 13. 09/28/24.

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F 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Regularly inspect all bed frames, mattresses, and bed rails (if any) for safety; and all bed rails and mattresses must attach safely to the bed frame. Based on observation, record review, and interview, the facility failed to ensure that the bed rail and bed were compatible for 1 (R #17) of 1 (R #17) resident reviewed for accidents. This deficient practice could likely result in serious injury if residents fall while attempting to transfer while using the bed rail. The findings are:A. On 12/10/25 at 1:37 PM, during an observation of R #17 in his bed, revealed that R #17's bed rail was loose. The bed rail moved side to side parallel to the length of the bed approximately 1 to 2 inches. The bed rail appeared to be an aftermarket attachment to the side of the bed. When R #17 reached for the bed rail to assist with getting up from lying down, the bed rail gave. B. Record review of R #17's medical record, no date, revealed that there was no documentation that the bed rail has been inspected for proper installation. C. On 12/10/25 at 4:26 PM, during an interview, the ADON confirmed that the bed rail was not sturdy. The ADON stated she did not know if the bed rail had been inspected for proper installation.