| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 325078 | A. Building<br>B. Wing | 11/17/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Retirement Ranches Inc. | 2221 Dillon<br>Clovis, NM 88101 |

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| F 0552<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Ensure that residents are fully informed and understand their health status, care and treatments.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure residents and/or their representatives were informed in advance of what medications they received and understood the reasons, risks, and benefits of the medications for 1 (R #2) of 2 (R #2 and R #5) residents reviewed for unnecessary medications. If the residents or their representatives are not informed of the risks and benefits of the medication or treatment alternatives, they are not able to make informed decisions regarding residents' care. The findings are:A. Record review of R #2's face sheet reveals R #2 was admitted to the facility on [DATE] with the following diagnosis:1. Major depressive disorder (a mental health disorder characterized by persistently depressed mood or loss of interest in activities, causing significant impairment in daily life).2. Adjustment disorder with mixed anxiety and depressed mood (a mental health condition characterized by significant emotional distress and behavioral changes that occur in response to a stressful life event).3. Generalized anxiety disorder (a common mental health condition characterized by excessive and persistent worry and anxiety that is difficult to control).4. Unspecified dementia, mild, with mood disturbance (a form of dementia that is mild, has not been specified to a particular type (like Alzheimer's or vascular dementia), and includes emotional changes such as depression, lack of interest/motivation, or loss of pleasure).B. Record review of R #2's physician's orders revealed the following: 1. An order for buspirone tablet (anxiolytic; medication used to treat anxiety disorders), 10 milligrams (mg). Give two tablets by mouth twice daily for major depressive disorder. Start date: 01/08/24.2. An order for hydroxyzine tablet (antihistamine; medications used to treat anxiety, allergic reactions and as a sedative before and after surgery), 25 milligrams (mg). Give one tablet by mouth at bedtime for major depressive disorder. Start date: 03/06/24.3. An order for Tylenol PM Extra Strength tablet (a combination mediation containing Acetaminophen [medication used to relieve mild to moderate pain and reduce fever] and Diphenhydramine hydrochloride [an antihistamine that promotes sleep]), 25-500 milligrams (mg). Give 1-2 tablets by mouth at bedtime for unspecified dementia with mood disturbance. Start date: 06/24/254. An order for Venlafaxine capsule (antidepressant: medication used to treat depression and various anxiety disorders) 150 milligrams (mg). Give 1 capsule by mouth one time daily for adjustment disorder with mixed anxiety and depressed mood. Start date 03/06/2023. C. Record review of R #2's medical record revealed the medical record did not contain any consent for the use of buspirone, hydroxyzine, Tylenol PM Extra Strength and Venlafaxine. D. On 09/25/25 at 12:37 pm, during an interview with the Director of Nursing (DON), she confirmed staff did not obtain the consent form for the use of psychotropic medications (psychotropic medication; any drug that affects brain activities associated with mental processes and behavior) for R #2. The DON confirmed staff are expected to complete the psychotropic medication consent form prior to the resident starting psychotropic medications and did not. |

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 0576<br><br>Level of Harm - Potential for minimal harm<br><br>Residents Affected - Many | Ensure residents have reasonable access to and privacy in their use of communication methods.<br><br>Based on interviews, the facility failed to ensure that residents are able to receive mail on Saturdays for all 83 residents residing at the facility as identified on the census provided by the Administrator (ADM) on 09/23/25. This deficient practice is likely to result in residents not receiving timely communication which could result in feelings of isolation. The findings are: A. On 09/24/25 at 3:00 pm, during the Resident's Council Meeting, the residents stated mail is not delivered on Saturdays and they would like to receive their mail when it is delivered to the facility. R #49 stated he has never received his mail on a Saturday, even when he is waiting for a package. B. On 09/25/24 at 1:33 pm, during an interview with the Social Services Director (SSD), she confirmed the mail is not delivered on the weekends. She stated she does not work on Saturdays so any mail that comes in over the weekend would not get delivered until Monday when she returns to work. |

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| F 0578<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to: 1. Ensure that all residents can request or refuse emergency and lifesaving care by failing to obtain and review residents' wishes regarding code status (instructions regarding the type of medical interventions a person wants in the event of a medical emergency), medical interventions (comfort measures such as pain relief or use of oxygen, use of medical treatment such as intubation) and artificial hydration/nutrition (the provision of nutrition and fluids by methods other than normal eating and drinking), 2. Establish mechanisms for documenting and communicating the residents' choices of advanced directives (a written instruction, such as a living will or durable power of attorney for health care, recognized under State law and relating to the provision of health care when the individual is incapacitated) to the staff responsible for residents' care. These deficient practices have the potential to affect all 83 residents residing at the facility as identified by the census provided by the Administrator on 09/23/25. If the facility does not know the residents' wishes and has no mechanisms for communicating the wishes to the staff responsible for providing care, then residents' wishes might not be followed. The findings are: R #3A. Record review of R #3's Face Sheet revealed the following: 1. R #3 was admitted to the facility on [DATE] with chronic kidney disease (CKD; impaired kidney function), acute kidney failure (sudden decline in kidney function), and hypertensive heart disease (heart disease caused by high blood pressure).2. The Advanced Directives section of the Face Sheet was blank. B. Record review of R #3's electronic health record (EHR) revealed the records did not contain any documentation stating what R #3's wishes are regarding medical interventions and artificial hydration/nutrition. R #4C. Record review of R #4's Face Sheet revealed the following: 1. R #4 was admitted to the facility on [DATE] with aphasia (disorder that results from damage to portions of the brain), hemiplegia (paralysis of the arm, leg, and trunk on the same side of the body) and hemiparesis (one-sided muscle weakness) following cerebral infarction (an area of dead tissue in the brain resulting from a blockage or narrowing in the arteries supplying blood and oxygen to the brain), chronic kidney disease, and hypertensive heart disease.2. The Advanced Directives section of the Face Sheet was blank. D. Record review of R #4's EHR revealed the records did not contain any documentation stating what R #4's wishes are regarding code status, medical interventions, and artificial hydration/nutrition. R #25E. Record review of R #25's Face Sheet revealed the following: 1. R #25 was admitted to the facility on [DATE] with Alzheimer's disease (a progressive brain disorder that damages memory, thinking, and learning skills), unspecified convulsions (unclassified seizures), acute respiratory failure, and myocardial infarction (heart attack). 2. The Advanced Directives section of the Face Sheet was blank. F. Record review of R #25's electronic health record (EHR) revealed the records did not contain any documentation stating what R #25's wishes are regarding medical interventions and artificial hydration/nutrition.G. On 9/26/25 at 11:07 am during an interview with Admissions Director (AD), she confirmed the facility does not have record of residents' wishes regarding full code status, medical intervention or artificial hydration/nutrition. The AD stated there is no additional documentation of the residents' wishes for residents who do not already have an advance directive. She stated if the resident is a DNR (do not resuscitate) then an emergency medical services DNR form is completed, however it does not contain information regarding medical interventions and artificial hydration/nutrition. She stated that residents are only asked about advanced directives during admission and are not reviewed on a regular basis. |

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| F 0583<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Keep residents' personal and medical records private and confidential.<br><br>Based on observation and interview, the facility failed to provide personal privacy for 3 (R #29, R #61 and R #64) of 4 (R #4, R #29, R #61, and R #64) residents reviewed for privacy when staff administered medications in the commons area of the building after not giving the residents the chance to choose whether they received their medications privately. This deficient practice is likely to cause residents to feel embarrassed or ashamed. The findings are: A. On 09/22/25 at 12:13 pm during an observation of the lunch meal, R #29 sat in the commons area near his room, Certified Medical Assistant (CMA #2) walked up to him and administered his medications. There were seven other residents, several staff members and one family member present in the commons area. B. On 09/24/25 at 8:10 am a random observation of the facility revealed the following: 1. R #61 sat in the commons area near her room when CMA #1 walked up to her and said, here are your meds while she administered medications. 2. R #64 sat in the commons area near his room when CMA #1 walked up to him and said these are your meds while she administered his medications. 3. There were five other residents, one staff member, and one family member present in the commons area. C. On 09/25/25 at 1:10 pm during an interview with the Director of Nursing (DON), she stated that medications should be administered privately and confirmed that the commons areas where meals are also served is not private. |

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| F 0657<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to update a resident's care plan to reflect new diagnosis and treatment plans for 1 (R #84) of 7 (R #1, R #8, R #10, R #14, R #30, R #80, and R #84) residents reviewed for comprehensive care plans. This deficient practice could likely result in resident care not being closely monitored and not managed to meet the needs of the residents. The findings are:<br><br>A. Record review of R #84's EHR (Electronic Health Record) revealed he was admitted to the facility on [DATE] with the following diagnosis:<br><br>1. Type II Diabetes Mellitus (DM2, a condition that results from insufficient production of insulin, causing high blood sugar),<br><br>2. Chronic combined systolic (congestive) and diastolic (congestive) heart failure (CHF; impaired heart function),<br><br>3. Hypertensive heart disease with heart failure (heart disease caused by high blood pressure),<br><br>4. Complete traumatic amputation of left great toe, sequela (left big toe removed because of long-term effects of diabetes mellitus,<br><br>5. Benign prostatic hyperplasia without lower urinary tract symptoms (a condition where the prostate gland enlarges but does not cause any noticeable urinary problems).<br><br>B. Record review of R #84's physician orders revealed the following:<br><br>1. An order for wound care dated 08/30/25,<br><br>2. An order for foley catheter (a thin, sterile tube inserted into the bladder to drain urine) care dated 09/10/25.<br><br>C. Record review of R #84's care plan, last reviewed on 09/18/25, revealed the following:<br><br>1. The Care Plan did not contain any information about wound care and interventions,<br><br>2. The Care Plan did not contain any information about catheter care and interventions.<br><br>D. On 09/26/25 at 1:00 pm, during an interview with the Director of Nursing (DON), she stated the care plan was not revised to include wound care and interventions or catheter care and interventions. The DON stated this does not meet her expectations and the care plan for R #84 should have been revised. |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.<br><br>Based on observation, record review, and interview, the facility failed to provide two-person assistance for 1 (R #61) of 3 (R #4, R #29, and R #61) residents reviewed for transfer care (assisting a resident to move from one place to another). This deficient practice could likely result in R #61 being injured during a transfer. The findings are: A. On 09/24/25 at 8:30 am, during a random observation of the facility, Certified Nursing Assistant (CNA) #1 brought a mechanical lift into R #61's room, CNA #1 closed the door behind her, there were no other staff in the room. Approximately 15 minutes later, CNA #1 came out of R #61's room. B. On 09/24/25 at 8:51 am during an interview with CNA #1, she confirmed that she transferred R #61 using a mechanical lift by herself. CNA #1 stated that she used a maxi lift (a type of mechanical lift) and they can be operated using one person.C. Record review of R #61's care plan dated 08/26/25 revealed R #61 is to transfer using a maxi lift and two persons assist. D. On 09/24/25 at 11:53 am during an interview with Certified Nursing Assistant Coordinator (CNAC), he confirmed that according to the care plan, R #61 requires two staff to assist during transfers. |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.<br><br>Based on observation and interview, the facility failed to store and serve food under sanitary conditions by not ensuring food items stored in facility's freezer were opened, labeled, and dated. This deficient practice is likely to affect 83 residents listed on the resident census list provided by the Administrator on 09/22/25 and could likely lead to foodborne illnesses in residents if food is not being stored properly and safe food handling practices are not adhered to. The findings are:A. On 09/22/25 at 10:43 am during observation of the facility's walk-in freezer the following items were found open, unlabeled and undated: 1. One open bag of what appeared to be frozen broccoli.2. One open bag of what appeared to be frozen pizza. 3. One open bag of what appeared to be frozen bacon. B. On 09/22/25 at 10:47 am during an interview with the Dietary Aide (DA) #1, she confirmed the items were not labeled and not dated. DA #1 stated it does not meet her expectations and everything in the fridge and freezer should be labeled and dated. |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide and implement an infection prevention and control program.<br><br>Based on observations and interviews, the facility failed to utilize enhanced barrier precautions (EBP; an infection control intervention) when providing direct care to 3 (R #4, R #12, and #15) of 3 (R #4, R #12, and #15) residents. Failure to utilize enhanced barrier precautions when performing direct care has the potential to spread organisms, diseases, and other health conditions among the residents. The findings are:A. On 08/22/25 at 10:15 am a random observation of the facility revealed the carts that held personal protective equipment (PPE; protective clothing, face masks, goggles, or other garments or equipment designed to protect the wearer's body from injury or infection) were located at the entrance to each pod (group of resident rooms located near each other). The carts were located approximately fifteen to twenty feet from the nearest resident room that required PPE to be utilized.<br><br>R #4<br><br>B. On 09/23/25 at 8:32 am during a random observation of the facility, a sign indicated EBP is required when providing direct care to R #4 was hanging on the wall near the entrance to his room. Certified Nurse Aide (CNA) #3 assisted R #4 into his room and closed the door behind them. CNA did not have any PPE with her. Approximately 20 minutes later CNA #3 and R #4 came out of the room.<br><br>C. On 09/23/25 at 8:55 am, during an interview with CNA #3, she confirmed she just assisted R #4 with personal care (direct care provided by staff to assist a resident with activities of daily living such as changing adult briefs, changing clothes, catheter care, showering, etc.) and did not utilize the required PPE.<br><br>R #12<br><br>D. On 09/23/25 at 9:17 am during a random observation of the facility, a sign indicated EBP is required when providing direct care to R #12 was hanging on the wall near the entrance to her room. CNA #4 assisted R #12 to her room and closed the door behind them. CNA #4 did not have any PPE with her. Approximately 25 minutes later, CNA #4 came out of the room.<br><br>E. On 09/23/25 at 9:45 am during an interview with CNA #4, she confirmed she just assisted R #12 with personal care and did not utilize the required PPE.<br><br>R #15<br><br>F. On 09/22/25 at 9:00 am, a random observation of R #15's room revealed a sign on the door that indicated R #15 was on enhanced barrier precautions (EBP), staff are required to wear personal protective equipment (PPE: gowns, masks, and gloves) when providing care for R #15.<br><br>G. On 09/22/25 at 1:43 pm during an observation of R #15's room, CNA #2 provided care (vital signs) for R #15. CNA #2 did not wear gloves, gowns or masks while providing direct care to R #15.<br><br>H. On 09/22/25 at 1:49 pm during an interview with CNA #2, she confirmed R #15 is on EPB, so staff should be wearing gloves, gowns, and masks to provide contact care and should have worn PPE for R #15.<br><br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | I. On 09/25/25 at 12:38 pm during an interview with the Director of Nursing (DON), she stated she expects all staff to utilize the required PPE using EBP precautions when providing direct care to residents that require EBP. |