STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	325086	A. Building B. Wing	03/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Casa Maria Healthcare	1601 South Main Street Roswell, NM 88203

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Actual harm Residents Affected - Some	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47899 Based on record review and interviews, the facility failed to prevent staff to resident sexual abuse and to protect other residents from ongoing sexual behaviors for 2 (R #1 & R #2) of 2 (R #1 and R #2) residents reviewed for abuse. This deficient practice likely resulted in psychosocial distress (unpleasant emotions associated with a highly stressful situation) for the residents who were subject to this behavior. The findings are: R #1 A. Record review of R #1's face sheet revealed she was admitted to the facility on [DATE]. R #1 was dependent on care on activities of daily living. Her diagnoses included but were not limited to: - Reduced mobility (severe chronic illness that requires immobilization in bed), - Need for assistance with personal care, - Spinal stenosis (narrowing of the spine) lumbar region, - Morbid severe obesity (overweight), and - Sepsis (life threatening condition that arises when the body's response to infection causes injury to its own tissues and organs). B. Record review of the Minimum Data Set (MDS; a federally mandated assessment instrument completed by facility staff) dated 11/30/23 identified R #1's Brief Interview for Mental Status (BIMS; tool to screen and identify the cognitive condition of long-term care residents 0 being the lowest and 15 being the highest) score was 15, cognitively intact. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0600 Level of Harm - Actual harm Residents Affected - Some	C. On 02/10/24 at 12:15 pm during an interview, R #1 stated she woke up startled in the early morning hours on 01/23/24 and found Certified Nursing Assistant (CNA) #1 standing by her bedside table. R #1 asked CNA #1 what he was doing in her room in the dark, and he left her room without responding. The next morning (01/24/24), R #1 told Registered Nurse (RN) #1 that CNA #1 was in her room the night prior and it scared her. R #1 asked that CNA #1 not be allowed back into her room. CNA #1 continued to work with the resident, which R #1 stated traumatized her emotionally. R #1 further reported that on 02/02/24, CNA #1 entered R #1's room and began to apply Desitin cream (diaper rash cream) to her pubic area. R #1 stated that CNA #1 began to apply the Desitin cream inside her vagina and touched her clitoris [the sensitive area located on the top of the vulva (the global term that describes all the structures that make the female external genitals] in a sensual manner. R #1 stated the incident happened so quickly, and it was over before she could tell CNA #1 to stop. CNA #1 put R #1's brief back on and left the room without saying anything. R #1 stated she was so terrified that CNA #1 would come back to her room that she did not use her call light for the rest of the night, even though she woke up with her bedding saturated with urine. R #1 stated she reported this to CNA #2. During the interview R #1 started to cry when she explained CNA #1 had touched her sexually when he rubbed Desitin on her, and she stated she feared him. D. Record review of the facility's staffing scheduled revealed CNA #1 was assigned to work with R #1 on the following shifts: - On 01/23/24, 6 pm-11:59 pm, - On 01/24/24, 12 am-6:00 am, - On 02/01/24, 6:00 pm-11:59 pm, - On 02/02/24, 12 am-6 am. E. Record review of the facility's staff schedule, dated 01/23/24 and 02/02/24, verified CNA #1 was assigned to work with R #1. F. Record review of R #1's Trauma Informed Assessment, dated 02/02/24 and completed by Social Services, revealed: 1. Is abuse, violence, or sexual assualt been an event in your life that has casued or cuases a problem for you in anyway? a. A black man broke into her apartment in 1976 and tried to rape her. (R #1 had an event in her life in 1976 in which a black male broke into her apartment.) 2. R #1 answered yes to the question Has there been a sudden event that made you feel very scared, helpless, or horrified? a. After CNA #1 stood in her room in the dark and stared at her while she was sleeping, and that she woke up suddenly. 3. R #1 answered yes to the question Have you had nightmares or thoughts about it happening when you did not want to? (continued on next page)

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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 0600 Level of Harm - Actual harm Residents Affected - Some	a. R #1 expressed concern about CNA #1 in her room and asked RN #1 to please make sure that she had a female CNA. CNA #1 returned, and R #1 felt CNA #1 was anxious but aware of what he was doing when administering Desitin around her private area. He placed the Desitin inside the vaginal area, internally. R #1 did not feel he had any business in that area, because this was not where the medication was supposed to go. 4. R #1 answered yes to the question Have you tried hard to not think about an event or went out of your way to avoid situations that reminded you of it? a. R #1 requested of staff several times for a female attendant. b. If yes, please describe: R #1 was watchful and guarded. Resident went 12 hours without allowing the male CNA to change her. The incident (sexual abuse) happened around 9:00 pm. R #1 allowed the morning nurse to change her at shift change, because the morning nurse was a female. 5. The assessment directed the assessor to evaluate for occurrence of trauma. The assessor documented no occurrence of trauma as resident would not allow herself to be touched by CNA #1 or any other male CNA. The resident only wanted a female in her room at this time. G. On 02/10/24 at 4:12 pm during an interview, RN #1 stated R #1 reported to him (on 01/24/24) that she woke up on the night of 01/23/24 and was startled by CNA #1 standing in the dark near her bed. He said R #1 told him that she was upset and did not wish for CNA #1 to be allowed back in her room. RN #1 stated he did not have the ability to change the schedule, and he did not report the incident to anyone. H. On 02/10/24 at 4:30 pm during an interview, CNA #2 stated R #1 was initially hesitant to discuss the incident between R #1 and CNA #1, but eventually the resident opened up about what happened (on 02/02/24). CNA #2 stated when she went into R #1's room the morning of 02/02/24, she found R #1 in a puddle of urine, and the resident urinated through her brief. CNA #2 stated she asked R #1 why no one had changed her throughout the night, and R #1 told her CNA #1 touched her sexually during first rounds. CNA #2 stated R #1 said she did not want to call CNA #1 back into the room so she urinated on herself until the morning shift came in. CNA #2 stated R #1 previously told her that CNA #1 made her (R #1) uncomfortable and was standing in her room in the dark. CNA #2 stated she reported the incident to the facility's administrator on 02/02/24. CNA #1 stated there was another resident (R #2) who expressed that she was afraid of CNA #1. CNA #2 could not ellbvorate on what she was afraid of, just that she was afraid. CNA #2 stated R #2 told her that she was scared of CNA #1, but CNA #2 was unable to give an exact date R #2 said this. CNA #2 stated she thought R #2 told her between 02/04/24 through 02/10/24. CNA #2 stated she did not tell anyone that R #2 reported being afraid of CNA #1. I. On 02/10/24, at 5:23 pm, during an interview with the Director of Nursing (DON), she confirmed the Desitin cream should have only been placed on the outside of R #1's groin area and not placed internally. (continued on next page)

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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 0600 Level of Harm - Actual harm Residents Affected - Some	J. On 02/12/24, at 10:41 am during an interview with the Administrator, she stated the facility offered to send R #1 to the emergency roiagnom on [DATE], but the resident declined. She stated that during the facility's investigation of the incident, they did the random safe survey with five residents on the same hall as R #1. The Administrator said the hall did not have a large female population. The Administrator said the police were called on 02/02/24, and she spoke with the police officer. The Administrator said R #1 told the police officer there was no wrongdoing. The Administrator stated, Mostly, our decision [to unsubstantiate the allegation] was based on [Name of R #1] saying there was no wrongdoing [to the police officer], and we attributed [the allegation] to her past trauma. The Administrator stated CNA #1 was suspended pending results of the investigation, and CNA #1 returned to work a few days later. K. Record review of the police report, dated 02/02/24, revealed law enforcement was called to the facility for possible elder abuse. The police report stated an officer was dispatched to the facility on [DATE], and the officer made contact with R #1. R #1 told the officer that about two weeks ago around 2:00 am and 3:00 am, she woke up to CNA #1 standing next to her bed just staring at her. R #1 told the officer she did not call CNA #1, and the CNA left the room when R #1 asked what he wanted. R #1 told the officer that she told RN #1 about the incident and asked for a different person to care for her. R #1 told the officer that on 02/01/24 CNA #1 took care of her again, and while CNA #1 applied medication to her vaginal area, he began to rub her clitoris. R #1 told the officer it made her feel uncomfortable to the point she did not call CNA #1 back to her room for care the rest of the night. R #1 told the officer she just laid there in a pool of urine until a female staff arrived. R #1 stated she did not want to press charges, but she was upset with how the facility handled the situation. R #2 L. Record review of R #2's face sheet revealed she was admitted on [DATE]. Her diagnosis included but were not limited to: Cerebral ischemia (a condition in which there is insufficient blood flow to the brain to meet metabolic demand), need for assistance with personal care, other reduced mobility, and weakness. M. Record review of the MDS, dated [DATE], identified R #2's BIMS score was 9, moderately impaired. N. On 02/10/24, at 4:45 pm during an interview, R #2 provided a physical description of CNA #1 and said the CNA attempted to touch her twice. R #2 was unable to give dates. R #2 pointed to her genitals. R #2 stated, I told him it [her body] was mine and to leave it alone. I am afraid of him. I am afraid of him around me, because he touched me. I didn't know who to tell. I am afraid of him. It happened the other night. O. Record review of the facility's staff schedule, dated 02/04/24 through 02/07/24, revealed CNA #1 worked on the hall where R #2's room was located and provided care for R #2. Further review revealed CNA #1 was the only male that worked with R #2 during that time. P. Record review of R #2's Trauma Informed Assessment, dated 02/10/24, completed by social services revealed: (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Some	1. R #2 reported a male staff member came in and tried to feel her up. The resident stated the staff member did not wear a badge, and she never saw him before. The assessor documented, He tried to play with her privates. 2. The assessor left questions 2 through 6 blank on the form. 3. R #2 stated she did not want that staff member to come to her room. The assessor documented, She is very horrified and on guard after what happened in her room. He should have been changing her but instead was touching down there. Q. On 02/12/24 at 10:41 am during an interview with the Administrator regarding R #2, she said they offered to have a physician examine R #2 on 02/10/24, but the resident declined. The administrator said they were currently doing an investigation and CNA #1 was suspended pending results of the investigation, CNA #1 had not returned to work at this time, and the facility filed a state report.

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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 0609 Level of Harm - Immediate jeopardy to resident health or safety 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** 47899 Based on record review and interview, the facility staff failed to report incidents of alleged abuse for 2 (R #1 and R #2) of 2 (R #1 and R #2) residents sampled. If the staff failed to report allegations of abuse to the facility administration then corrective measures may not be acted on, and the facility would be unable to assure residents are free from abuse and neglect. The findings are: R #1 A. Record review of R #1's face sheet revealed she was admitted to the facility on [DATE]. R #1 was dependent on care on activities of daily living. Her diagnoses included but were not limited to: - Reduced mobility (severe chronic illness that requires immobilization in bed), - Need for assistance with personal care, - Spinal stenosis (narrowing of the spine) lumbar region, - Morbid severe obesity (overweight), and - Sepsis (life threatening condition that arises when the body's response to infection causes injury to its own tissues and organs). B. Record review of the Minimum Data Set (MDS; a federally mandated assessment instrument completed by facility staff), dated 11/30/23, identified R #1's Brief Interview for Mental Status (BIMS; tool to screen and identify the cognitive condition of long-term care residents 0 being the lowest and 15 being the highest) score was 15, cognitively intact. C. On 02/10/24 at 2:15 pm during an interview, R #1 stated she woke up startled in the early morning hours on 01/23/24 and found Certified Nursing Assistant (CNA) #1 standing by her bedside table. R #1 asked CNA #1 what he was doing in her room in the dark, and he left her room without responding. The next morning (01/24/24), R #1 told Registered Nurse (RN) #1 that CNA #1 was in her room the night prior and it scared her. R #1 asked that CNA #1 not be allowed back into her room. CNA #1 continued to work with the resident, which R #1 stated traumatized her emotionally. D. Record review of the facility's staffing scheduled revealed CNA #1 was assigned to work with R #1 on the following shifts: - On 01/23/24, 6 pm-11:59 pm, - On 01/24/24, 12 am-6:00 am, - On 02/01/24, 6:00 pm-11:59 pm, - On 02/02/24, 12 am-6 am. (continued on next page)

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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 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	E. Record review of the facility's staff schedule, dated 01/23/25 and 02/01/24, verified CNA #1 was assigned to work with R #1 F. On 02/10/24 at 4:12 pm during an interview, RN #1 stated R #1 reported to him (on 01/24/24) that she woke up on the night of 01/23/24 and was startled by CNA #1 standing in the dark near her bed. He said R #1 told him that she was upset and did not wish for CNA #1 to be allowed back in her room. RN #1 stated he did not have the ability to change the schedule, and he did not report the incident to anyone. G. On 02/10/24 at 4:30 pm during an interview, CNA #2 stated R #1 previously told her that CNA #1 made her (R #1) uncomfortable and was standing in her room in the dark. CNA #2 stated she was aware of another resident (R #2) who expressed that she was afraid of CNA #1. The CNA stated that R #2 told her that she was scared of CNA #1. CNA #2 was unable to give the exact date R #2 said this, but she thought it occurred between 02/04/24 through 02/10/24. CNA #2 stated she did not tell anyone that R #2 reported being afraid of CNA #1. R #2 H. Record review of R #2's face sheet revealed she was admitted on [DATE]. Her diagnoses included but were not limited to the following: Cerebral ischemia (a condition in which there is insufficient blood flow to the brain to meet metabolic demand), need for assistance with personal care, other reduced mobility, and weakness. I. Record review of the MDS, dated [DATE], identified R #2's BIMS score was 9, moderately impaired. J. Record review of the facility's staff schedule, dated 02/04/24 through 02/07/24, revealed CNA #1 worked on the hall where R #2's room was located and provided care for R #2. CNA #1 was the only male that had worked with R #2 during that time. Based on interview and record review, Immediate Jeopardy was identified on 03/15/24 at 4:20 pm to the administrator, in person. The facility took corrective action by proving an acceptable Plan of Removal (POR) on 03/14/24 at 4:31 pm. Implementation of the POR was verified onsite on 03/13/24 by interviewing staff regarding the education that had been given, and offsite on 03/14/24 with the completion of the resident audits regarding if any of the residents felt safe or felt abused. Plan of removal: The Nurse was educated on abuse reporting on 02/26/24. The CNA was educated on abuse reporting on 03/13/24. The facility conducted a safety audit of all residents in the building was completed on 03/14/24. The facility has begun to conduct random staff questionaries on abuse and reporting. Date started 03/13/24. Total number of staff interviewed = 27. (continued on next page)

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F 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Have you heard of a resident being abused in our facility? What did you do about it? Do you know who to report it to? There are no grievances identified that abuse or neglect was indicated or required further reporting.

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47899 Based on record review and interview, the facility failed to complete a thorough investigation regarding allegations of sexual abuse for 1 (R #1) of 1 (R #1) residents that CNA #1 worked with. This failure could likely lead to other residents' being sexully abused. The findings are: R #1 A. Record review of R #1's face sheet revealed she was admitted to the facility on [DATE]. R #1 was dependent on care for activies of daily living. Her diagnoses included but were not limited to: - Reduced mobility (severe chronic illness that requires immobilization in bed), - Need for assistance with personal care, - Spinal stenosis (narrowing of the spine) lumbar region, - Morbid severe obesity (overweight), and - Sepsis (life threatening condition that arises when the body's response to infection causes injury to its own tissues and organs). B. Record review of the Minimum Data Set (MDS; a federally mandated assessment instrument completed by facility staff), dated 11/30/23, identified R #1's Brief Interview for Mental Status (BIMS; tool to screen and identify the cognitive condition of long-term care residents 0 being the lowest and 15 being the highest) score was 15, cognitively intact. C. On 02/10/24 at 12:15 pm during an interview, R #1 revealed she woke up startled in the early morning hours on 01/23/24 and found Certified Nursing Assistant (CNA) #1 standing by her bedside table. R #1 asked CNA #1 what he was doing in her room in the dark, and he left her room without responding. The next morning (01/24/24), R #1 told Registered Nurse (RN) #1 that CNA #1 was in her room the night prior and it scared her. R #1 asked that CNA #1 not be allowed back into her room. CNA #1 continued to work with the resident, which R #1 stated traumatized her emotionally. R #1 further reported that on 02/02/24, CNA #1 entered R #1's room and began to apply Desitin cream (diaper rash cream) to her pubic area. R #1 stated that CNA #1 began to apply the Desitin cream inside her vagina and touched her clitoris [the sensitive area located on the top of the vulva (the global term that describes all the structures that make the female external genitals] in a sensual manner. R #1 stated the incident happened so quickly, and it was over before she could tell CNA #1 to stop. CNA #1 put R #1's brief back on and left the room without saying anything. R #1 stated she was so terrified that CNA #1 would come back to her room that she did not use her call light for the rest of the night, even though she woke up with her bedding saturated with urine. R #1 stated she reported this to CNA #2. D. Record review of the facility's staffing scheduled revealed CNA #1 was assigned to work with R #1 on the following shifts: - On 01/23/24, 6 pm-11:59 pm, (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	- On 01/24/24, 12 am-6:00 am, - On 02/01/24, 6:00 pm-11:59 pm, - On 02/02/24, 12 am-6 am. E. Record review of R #1's Trauma Informed Assessment, dated 02/02/24 and completed by Social Services, and answered by R #1 revealed: 1. Is abuse, violence, or sexual assault been an event in your life that has caused or causes a problem for you in any way? a. A black man broke into her apartment in 1976 and tried to rape her. (R #1 had an event in her life in 1976 in which a black male broke into her apartment. 2. R #1 answered yes to the question Has there been a sudden event that made you feel very scared, helpless, or horrified? a. After CNA #1 she was sleeping, and that she woke up suddenly. 3. R #1 answered yes to the question Have you had nightmares or thoughts about it happening when you did not want to? a. R #1 expressed concern about CNA #1 in her room and asked RN #1 to please make sure that she had a female CNA. CNA #1 returned, and R #1 felt CNA #1 was anxious but aware of what he was doing when administering Desitin around her private area. He placed the Desitin inside the vaginal area, internally. R #1 did not feel he had any business in that area, because this was not where the medication was stood in her room in the dark and stared at her while upposed to go. 4. R #1 answered yes to the question Have you tried hard to not think about an event or went out of your way to avoid situations that reminded you of it? a. R #1 requested of staff several times for a female attendant. b. If yes, please describe: R #1 was watchful and guarded. Resident went 12 hours without allowing the male CNA to change her. The incident (sexual abuse) happened around 9:00 pm. R #1 allowed the morning nurse to change her at shift change, because the morning nurse was a female. 5. The assessment directed the assessor to evaluate for occurrence of trauma. The assessor documented no occurrence of trauma as resident would not allow herself to be touched by CNA #1 or any other male CNA. The resident only wanted a female in her room at this time. F. On 02/10/24 at 4:12 pm during an interview, RN #1 stated R #1 reported to him [on 01/24/24] that she woke up on the night of 01/23/24 and was startled by CNA #1 standing in the dark near her bed. He said R #1 told him that she was upset and did not wish for CNA #1 to be allowed back in her room. RN #1 stated he did not have the ability to change the schedule, and he did not report the incident to anyone. (continued on next page)

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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 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	G. On 02/10/24 at 4:30 pm during an interview, CNA #2 stated R #1 was initially hesitant to discuss the incident between R #1 and CNA #1, but eventually the resident opened up about what happened (on 02/02/24). CNA #2 stated when she went into R #1's room the morning of 02/02/24, she found R #1 in a puddle of urine and the resident urinated through her brief. CNA #2 stated she asked R #1 why no one had changed her throughout the night, and R #1 told her CNA #1 touched her sexually during first rounds. CNA #2 stated R #1 said she did not want to call CNA #1 back into the room so she urinated on herself until the morning shift came in. CNA #2 stated R #1 previously told her that CNA #1 made her (R #1) uncomfortable and was standing in her room in the dark. CNA #2 stated she reported the incident to the facility's administrator on 02/02/24. H. On 02/10/24 at 5:23 pm during an interview with the Director of Nursing (DON), she stated Desitin cream should have only been placed on the outside of R #1's groin area and not placed internally. I. On 02/12/24, at 10:41 am during an interview with the Administrator, she stated the facility offered to send R #1 to the emergency roiagnom on [DATE], but the resident declined. She stated that during the facility's investigation of the incident, they did the random safe survey with five residents on the same hall as R #1. The Administrator said the hall did not have a large female population. The Administrator said the police were called on 02/02/24, and she spoke with the police officer. The Administrator said R #1 told the police officer there was no wrongdoing. The Administrator stated, Mostly, our decision [to unsubstantiate the allegation] was based on [Name of R #1] saying there was no wrongdoing [to the police officer], and we attributed [the allegation] to her past trauma. The Administrator stated CNA #1 was suspended pending results of the investigation, and CNA #1 returned to work a few days later. J. Record review of the police report, dated 02/02/24, revealed law enforcement was called to the facility for possible elder abuse. The police report stated an officer was dispatched to the facility on [DATE], and the officer made contact with R #1. R #1 told the officer that about two weeks ago around 2:00 am and 3:00 am, she woke up to CNA #1 standing next to her bed just staring at her. R #1 told the officer she did not call CNA #1, and the CNA left the room when R #1 asked what he wanted. R #1 told the officer that she told RN #1 about the incident and asked for a different person to care for her. R #1 told the officer that on 02/01/24 CNA #1 took care of her again, and while CNA #1 applied medication to her vaginal area, he began to rub her clitoris. R #1 told the officer it made her feel uncomfortable to the point she did not call CNA #1 back to her room for care the rest of the night. R #1 told the officer she just laid there in a pool of urine until a female staff arrived. R #1 stated she did not want to press charges, but she was upset with how the facility handled the situation. Based on interview and record review, Immediate Jeopardy was identified on 03/15/24 at 4:20 pm to the administrator, in person. The facility took corrective action by proving an acceptable Plan of removal (POR) on 03/14/24 at 4:31 pm. Implementation of the POR was verified offsite on 03/14/24 with completion of resident audits regarding if any of the residents felt safe or felt abused. Plan of removal: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	325086	A. Building B. Wing	03/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Casa Maria Healthcare	1601 South Main Street Roswell, NM 88203

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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 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The center has implemented a new process to identify residents who may also be affected by an allegation of abuse. The process change includes widening the interview pool to include residents with a BIMS <11 that was not previously in place to ensure the identification of others. To continue compliance each state reportable that includes an allegation of abuse or neglect will be reviewed by a corporate partner to ensure interviews were conducted on all residents residing in the center prior to the 5 day being submitted. If an employee has an allegation of abuse or neglect against them, the IDT will meet, including Social Services, Human Resources, Director of Nursing, and and Administrator, (or their designee) and make a decision to keep or terminate the employee based on the investigation. This process will start on 03/13/24 when the RNC ([NAME] nurse consultant) educated the Administrator and Director of Nursing on performing interviews with all residents that could be at risk of an alleged incident.