

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  325086	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  02/05/2026
NAME OF PROVIDER OR SUPPLIER  Casa Maria Healthcare		STREET ADDRESS, CITY, STATE, ZIP CODE  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)
<p>F 0604</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on interview and record review, the facility failed to prevent misappropriation of resident money when a payment app account was used by a staff member for 1 (R #1) of 4 (R #1, R #2, R #3 and R #4) residents reviewed for exploitation (the fact of making use of a situation to gain unfair advantage for oneself). This deficient practice is likely to cause residents to feel unsafe, and experience anger and frustration. The findings are:A. Record review of R #1's admission Record revealed she was admitted to the facility on [DATE] with the following diagnoses:1. Hypertrophic cardiomyopathy (heart disease),2. Non-ST Elevated (NSTEMI) Myocardial Infarction (a typer of heart attack),3. Type 2 diabetes mellitus (DM2, a condition that results from insufficient production of insulin, causing high blood sugar),4. Gastroesophageal reflux disease (GERD; A digestive disease in which stomach acid or bile irritates the food pipe lining),5. Cognitive communication deficit (impairments to cognitive functions).B. Record review of R #1's Minimum Data Set (MDS; a federally mandated assessment instrument completed by facility staff) dated 12/19/25, revealed a Brief Interview for Mental Status (BIMS; a screening for cognitive impairment) score of 11, moderately impaired.C. Record review of the facility's Initial Incident Report dated 01/19/26 revealed R #1 reported to the facility that Certified Nurse Aide (CNA) 1 took R #1's phone without R #1's knowledge and transferred \$100.00 to CNA #1's account without R #1's permission. D. Record review of the facility's Investigative Narrative Report (report of the facility's investigation and findings) dated 01/19/26 revealed the following:1. \$100.00 was withdrawn from R #1's payment app account on 12/16/25.2. CNA #1 used R #1's phone to transfer \$100.00 to CNA #1's personal payment app account.3. The allegation of exploitation against CNA #1 is substantiated.E. On 02/05/26 at 3:00 pm during an interview with R #1, she stated that her phone had been used by CNA #1 to transfer \$100.00 from her personal payment app account to CNA #1's account. R #1 stated that she did not know CNA #1 used her phone because she never gave CNA #1 permission to use it. R #1 stated she realized the money was missing when she received her bank statement in January 2026. R #1 stated that she was happy to get the money back and chose not to file charges.F. On 02/05/26 at 3:40 pm during an interview with Administrator (ADM), he stated that R #1's son contacted the facility claiming that CNA #1 transferred \$100.00 of R #1's money to CNA #1's personal account. The ADM stated the investigation that he conducted did confirm the allegation of exploitation which led him to file a police report and terminate CNA #1's employment.</p>

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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:  Facility ID: 325086	If continuation sheet Page 1 of 1