

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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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 06/25/2026
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)		
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interviews, the facility failed to complete a physician-ordered referral to an orthopedic specialist for post-fall follow-up care for 1 (R #1) of 3 (R #1, R #2, and R #3) residents reviewed. This deficient practice could result in a delay in evaluation and treatment for possible injuries. The findings are: A. Record review of the facility's Resident Care and Services policy, dated 01/2026, revealed the following:1. Residents are provided with the necessary care and services to maintain the highest practicable physical, mental, and social well-being in an environment that enhances quality of life in the scope of a long-term care facility. Care and services are provided in a manner that consistently enhances self-esteem and self-worth.2. Residents will be informed about medical treatments and have the right to refuse care. B. Record review of R #1's Face Sheet revealed she was admitted to the facility on [DATE] with the following diagnoses:1. History of falling,2. Osteoporosis (bones become extremely porous and are subject to fracture and slow healing),3. Difficulty in walking. C. Record review of R #1's annual Minimum Data Set (MDS; a federally mandated assessment instrument completed by facility staff), dated 05/13/26, revealed the following:1. A Brief Interview for Mental Status (BIMS; a screening for cognitive impairment) score of 14, cognitively intact.2. R #1 required supervision or touching assistance (helper provides verbal cues and/or touching/steadying and/or contact guard assistance as the resident completed the activity). D. Record review of R #1's Progress Notes revealed the following:1. Dated 05/12/26:- R #1 sustained a fall in the restroom while taking a shower. She slipped between the shower wall and the toilet and fell back onto the toilet seat. She did not inform nursing of the fall, because she was not injured and did not feel the need to report it.- R #1 reported left shoulder pain later the same evening to the nurse on duty. R #1 informed the nurse she slipped in the shower and fell back onto the toilet seat. R #1 did not hurt herself and did not think she needed to tell anyone.- The nurse on duty assessed R #1's pain at 2 out of 10 (one to ten pain scale; 0 means no pain and 10 represents the worst pain imaginable).- The nurse on duty notified the provider and the nurse manager that R #1 had an unwitnessed fall. The provider instructed staff to monitor according to facility protocol, notify the provider of any changes in patient's condition, and to ensure all safety measures were in place.- The nurse on duty administered 650 milligrams (mg) of acetaminophen (oral pain medication) for R #1's generalized discomfort.2. Dated 05/13/26, R #1 obtained a mobile x-ray (portable imaging system designed to bring X-ray capabilities directly to the patient's location) ordered for shoulder pain.3. Dated 05/14/26, R #1 was seen by a provider for a follow-up on her shoulder pain from a fall on 05/12/26. New orders were not issued.4. Dated 05/14/26, R #1's x-ray results revealed a left closed nondisplaced fracture of the surgical neck of left humerus (a break/crack in the upper left arm). Orders for R #1 to wear her arm in a sling for four weeks, non-weight bearing, and a referral to an orthopedic provider. E. Record review of R #1's Radiology Report, dated 05/14/26, revealed the x-ray was unable to determine if the fracture was recent or an old fracture. F. Record review of R #1's Physician Orders, dated 05/14/26, revealed an order for R #1 to be referred to an orthopedic specialist for her left shoulder. G. Record review of the facility's Referral Log, not dated, revealed there was not any documentation indicating staff scheduled or completed R #1's orthopedic referral. H. On 06/25/26 at 10:00 am, during 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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 325086 If continuation sheet Page 1 of 2

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	observation and interview, R #1 stated her left shoulder hurt a little. She stated she did not see an orthopedic specialist. R #1 stated her pain was a 2 out of 10 on the pain scale. R #1 grimaced when she touched her shoulder to indicate where her pain was. R #1 stated she wanted to talk to the orthopedic specialist to see if surgery was an option, but she did not hear anything from the facility about an appointment being scheduled. I. On 06/25/26 at 1:15 pm, during an interview, Medical Records (MR) stated she was responsible for making all resident appointments in the facility. The MR stated a provider made a referral to the nursing staff. She stated the nursing staff were supposed to bring the referral to her, so she could track the referral and make the appointment. The MR stated the nursing staff did not inform her about R #1's referral to an orthopedic specialist, so she did not make the appointment. J. On 06/25/26 at 1:26 pm, during an interview, the Director of Nursing (DON) stated he was not aware of R #1's referral to an orthopedic specialist, because he was new to the building. The DON stated there was not any evidence staff completed the orthopedic referral. The DON stated this did not meet his expectations, because all referral appointments should be started as soon as the nursing staff receive the referral. He stated it was expected for the nursing staff to pass it on to Medical Records, so Medical Records could schedule the appointment within one or two business days.		