| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 325086 | A. Building<br>B. Wing | 12/18/2025 |

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

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|---|---|
| F 0561<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure residents were provided activities according to their preference for 1 (R #4) of 1 (R #4) resident reviewed for activities of daily living. This deficient practice is likely to result in the residents' personal choices not being honored and loss of dignity. The findings are: A. Record review of R #4 admission record revealed R #4 was admitted on [DATE].B. Record review of R #4's care plan, revised on 06/22/24 revealed R #4 prefers activities that identify with prior lifestyle. She prefers current events, educational programs, movies, sports, and television.C. On 12/14/25 at 3:52 pm during an interview with R #4, she stated she was upset because the facility had taken the power strip that connected her television to the outlet earlier this morning. She stated she could not watch television anymore because the television cord does not reach the outlet. She stated the facility informed her that it was a safety hazard.D. Record review of the facility's Electrical Safety for Residents policy revision January 2011, revealed when power strips are used the following precaution must be taken:1. Install internal ground faults and over-current protection devices,2. Secure power strips so that they do not cause trip hazards,3. Use power strips that are adequate for the number and types of devices used. E. On 12/17/25 at 1:33pm during an interview with the Administrator (ADM), he confirmed the power strip was removed from R #4's room. The administrator stated the facility was consulting an electrician to make changes to the outlets however alternatives were not put in place to allow residents to continue to watch tv in their room. |

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 0578<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | 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 ensure the resident's current advance directive (a document which provides an individual's wishes for emergency and lifesaving care) and the resident's Electronic Health Record (EHR) revealed the same resident wishes for 3 (R #9, R #79, and R #84) of 6 (R #9, R #10, R #63, R #67, R #79, and R #84) residents reviewed for advance directives. This deficient practice is likely to cause confusion and delay potentially lifesaving procedures. The findings are:R #9A. Record review of the face sheet in R #9's EHR revealed R #9 was admitted into the facility on [DATE], and his current Advance Directive was listed as Attempt Resuscitation/CPR (CPR; a lifesaving emergency measure that combines chest compression with artificial ventilation are desired). B. Record review of R #9's MOST (MOST; a legal document which outlines the care the resident wants when they become incapacitated and unable to speak for themselves) form revealed the form was signed and dated [DATE] and revealed R #9's advance directive was Do Not Resuscitate (DNR; lifesaving measures are not desired).C. Record review of R #9's Physician's order dated [DATE] revealed and order to Attempt Resuscitation/CPR.D. Record review of R #9's Care Plan revision dated [DATE], documented R #9 as a Full Code (lifesaving procedures desired). E. On [DATE] at 3:24 pm, during an interview with Director of Nursing (DON), she confirmed that all of R #9's paperwork in the medical chart including face sheet, physician orders, and care plan revealed Full Code/Attempt CPR and the MOST form revealed DNR. She stated this does not meet her expectations and all Advance Directive documentation should match throughout the chart. R #79F. Record review of R #79's admission Record revealed she was admitted to the facility on [DATE].G. Record review of R #79's MOST form dated [DATE] revealed R #79 chose not to attempt resuscitation/DNR.H. Record review of R #79's current physician orders dated [DATE] revealed an order to attempt resuscitation/CPR.I. Record review of R #79's care plan dated [DATE] revealed it does not indicate any advance directive.J. On [DATE] at 3:00 pm during an interview with the DON, she confirmed R #79's physician order and care plan should match the signed MOST form and it does not. R #84K. Record review of R #84's face sheet revealed R #84's code status is Do Not Resuscitate.L. Record review of R #84's MOST form signed and dated [DATE] revealed R #84's wishes to Do Not Resuscitate.M. Record review of R #84's Physician's orders dated [DATE] revealed an Advance Directive order as Full code/CPR.N. Record review R #84's of Care Plan dated [DATE] did not include an Advance Directive. O. On [DATE] at 3:24 pm, during an interview with Director of Nursing (DON), she confirmed all of R #84's Advance Directed information was not documented correctly in care plan and the physician orders should match the MOST form. She stated this does not meet her expectations and all Advance Directive documentation should match throughout the chart. |

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| F 0605<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function.<br><br>**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 the medication was medically necessary for 2 (R #2 and R #4) of 3 (R #2, R #4 and R #54) residents reviewed for unnecessary medications, when staff failed to: 1. Ensure psychotropic medications were necessary to treat a specific condition as diagnosed and documented in the clinical record for R #2 and R #4, 2. Ensure as needed psychotropic medications are limited to only 14 days or indicate the duration of the as needed (PRN) order for R #2. These deficient practices could likely lead to adverse drug effects and poor patient outcomes. The findings are:R #2A. Record review of R #2's admission record revealed she was admitted into the facility on [DATE] with the following diagnoses:1. Insomnia (a common sleep disorder making it hard to fall asleep, stay asleep),2. Major depressive disorder (a mental health disorder characterized by persistently depressed mood or loss of interest in activities, causing significant impairment in daily life),3. Psychotic Disorder (a severe mental illness causing a loss of touch with reality). B. Record review of R #2's physician orders revealed an order for Lorazepam (anti-anxiety medication) Oral Tablet 0.5 milligrams (MG). Give 1 tablet by mouth every 4 hours as needed for anxiety, restlessness. Start Date: 11/11/25. C. Record review of R #2's monthly Medication Administration Record (MAR) for December 2025 revealed R #2 was administered Lorazepam on the following days:1. 12/06/25 at 3:00 am2. 12/06/25 at 9:10 am3. 12/10/25 at 9:52 pm4. 12/13/25 at 7:33 amR #4D. Record review of R #4's admission record revealed she was admitted into the facility on [DATE] with the following diagnoses: 1. Schizophrenia (a disorder that affects an individual's ability to think, feel, and behave clearly),2. Dementia (a group of conditions characterized by impairment of at least two brain functions, such as memory loss and judgment),3. Parkinsonism (a general term for movement disorders sharing symptoms with Parkinson's disease),4. Major Depressive Disorder (a mental health disorder characterized by persistently depressed mood or loss of interest in activities, causing significant impairment in daily life),5. Anxiety Disorder (mental health conditions causing intense, excessive, and persistent fear or worry that significantly interferes with daily life). E. Record review of R #4's physician orders revealed the following:1. Olanzapine Oral Tablet 10 milligrams (MG). Give 1 tablet by mouth two times a day for mood. Start date 03/27/24.2. Trazadone hydrochloride (HCl: antidepressant medication) Oral Tablet. Give 75 mg by mouth at bedtime for Insomnia. Start date 04/21/25. F. Record review of R #4's monthly Medication Administration Record (MAR) for December 2025 revealed: 1. R #4 was administered Olanzapine two times daily from 12/01/25-12/15/25.2. R #4 was administered Trazadone daily from 12/01/25-12/15/25. G. On 12/18/25 at 12:10 pm, during an interview with the Director of Nursing (DON), she confirmed the following:1. R #2 has an active order for Lorazepam for anxiety. This order is not limited to 14 days nor does it indicate the duration of the PRN order. 2. R #2 does not have a diagnosis of anxiety. 3. R #4 has an active order for Olanzapine however mood is not an appropriate indication of use. 4. R #4 has an active order for Trazadone for insomnia. 5. R #4 does not have a diagnosis of insomnia. The DON stated this does not meet her expectation. Medications should have an appropriate indication of use related to the residents' diagnosis. PRN psychotropics should indicate the duration or be limited to 14 days. |

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| F 0655<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed to create an accurate and complete baseline care plan (minimum healthcare information necessary to properly care for a resident immediately upon their admission to the facility) within 48 hours of admission for 4 (R #7, R #15, R #79, R #106) of 6 (R #7, R #8, R #15, R #35, R #79, and R #106) residents reviewed for care plans. This deficient practice could likely result in residents not receiving the appropriate care and may place residents at risk of an adverse event (undesirable experience, preventable or non-preventable, that caused harm to a resident because of medical care or lack of medical care) or worsening of current condition after admission. The findings are:R #15A. Record review of R #15's admission Record revealed she was admitted to the facility on [DATE] with the following diagnoses:1. Unspecified nondisplaced fracture (break) of surgical neck of left humerus (bone of the upper arm, forming a joint at the shoulder and elbow),2. Unspecified fracture of the lower end of right radius, (one of two larger bones in forearm),3. Depression (a mood disorder that causes a persistent feeling of sadness and loss of interest),4. Anxiety (feelings of fear or apprehension).B. Record review of R #15's Baseline Care Plan dated 05/10/25 revealed that staff failed to complete and sign the document until 05/17/25, missing the 48-hour deadline.C. On 12/18/25 at 12:00 pm during an interview with the DON, she confirmed R #15's Baseline Care Plan does not meet her expectations because it was completed thirteen days after admission. R #79D. Record review of R #79's admission Record revealed she was admitted to the facility on [DATE] with the following diagnoses:1. Unspecified fracture (break) of sacrum (a large flat bone in the lower part of the spine, forming the rear section of the pelvis),2. Essential (primary) hypertension (HTN; high blood pressure),3. Osteoarthritis (chronic degeneration of the joint cartilage),4. Retention of urine (condition where the bladder does not empty completely, leading to difficulty in urinating and potential health complications).E. Record review of R #79's Baseline Care Plan 11/26/25 revealed it was marked completed on 11/26/25 and was signed by the last author (activity director) on 12/09/25, missing the 48-hour deadline.F. On 12/18/25 at 12:00 pm during an interview with the DON, she confirmed R #79's Baseline Care Plan does not meet her expectations because it was completed eighteen days after admission.R #106G. Record review of R #106's admission Record revealed he was admitted to the facility on [DATE] with the following diagnoses:1. Displaced intertrochanteric fracture of right femur (hip fracture that occurs between the two bony protrusions at the top of the thigh bone),2. Chronic respiratory failure with hypoxia (low levels of oxygen in the body tissues),3. Collapsed vertebra(small bones forming the back bone), lumbar (lower part of the spine) region,4. Wedge compression fracture of T11-T12 vertebra (a break in a backbone that collapse on one side resulting in a wedge shape),5. Gastrostomy (a surgical opening into the stomach through the outer wall of the abdomen) status,6. Personal history of antineoplastic (inhibit or prevent the growth and spread of tumors or malignant cells) chemotherapy (chemical substance used to treat cancer) and irradiation (expose to radiation),7. Long term (current) use of anticoagulants (blood thinner).H. On 12/14/25 at 2:20 pm, during an interview and observation with R #106 in his room, R #106 had a feeding pump (medical device used to deliver liquid nutrition) connected through a tube in his abdomen. R #106 stated he has had a feeding tube since he had cancer eight years ago. I. Record review of Minimum Data Set (MDS; a federally mandated assessment instrument completed by facility staff) dated 12/15/25:1. Section J: Current Tobacco Use answer is yes,2. Section N: Medications, Anticoagulant use is currently taking.J. Record review of R #106's Baseline Care Plan dated 12/12/25 revealed the following:1. The Nursing Services section (Bb of section one) does not indicate that R #106 is a current<br><br>(continued on next page) |

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| F 0655<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | smoker. 2. The Nursing Services section (Cc of section one) does not indicate that R #106 currently takes an anticoagulant. 3. The nutritional services section (section four) does not contain any information.K. On 12/18/25 at 12:00 pm during an interview with the DON, she stated R #106's Baseline Care Plan does not meet her expectations because it should indicate that he is a current smoker, he currently takes an anticoagulant and uses a feeding tube, but it does not. |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed to create an accurate baseline care plan (minimum healthcare information necessary to properly care for a resident immediately upon their admission to the facility) within 48 hours of admission for 4 (R #7, R #15, R #79, R #106) of 6 (R #7, R #8, R #15, R #35, R #79, and R #106) residents reviewed for care plans. This deficient practice could likely result in residents not receiving the appropriate care and may place residents at risk of an adverse event (undesirable experience, preventable or non-preventable, that caused harm to a resident because of medical care or lack of medical care) or worsening of current condition after admission. The findings are:R #7A. Record review of R #7's admission Record revealed she was admitted to the facility on [DATE] with the following diagnoses:1. Metabolic encephalopathy2. End Stage Renal DialysisB. Record review of R #7's Baseline Care Plan revealed the following:1. The Social Services section (section two) does not contain any information.2. The Rehabilitative Services section (section three) does not contain any information.3. The Nutritional Services section (section four) states R #7 should be on a regular diet and was signed by the Director of Nutritional Services on 08/30/25.4. The Activities section (section five) does not contain any information.C. On 12/18/25 at 12:00 pm during an interview with the Director of Nursing (DON) she stated that R #7's baseline care plan does not meet her expectations because it is not accurate and not completed.R #15D. Record review of R #15's admission Record revealed she was admitted to the facility on [DATE] with the following diagnoses:1. Unspecified nondisplaced fracture of surgical neck of left humerus2. Unspecified fracture of the lower end of right radius3. Depression4. Anxiety disorderE. Record review of R #15's Baseline Care Plan revealed that it was not completed and signed until 05/22/25.F. On 12/18/25 at 12:00 pm during an interview with the DON, she confirmed that R #15's Baseline Care Plan does not meet her expectations because it was completed thirteen days after admission. R #79G. Record review of R #79's admission Record revealed she was admitted to the facility on [DATE] with the following diagnoses:1. Unspecified fracture of sacrum2. Essential (primary) hypertension3. Osteoarthritis4. Retention of urineH. Record review of R #79's Baseline Care Plan revealed it was marked completed on 11/26/25 and was signed by the last author (activity director) on 12/09/25.I. On 12/18/25 at 12:00 pm during an interview with the DON, she confirmed that R #79's Baseline Care Plan does not meet her expectations because it was completed eighteen days after admission.R #106J. Record review of R #106's admission Record revealed he was admitted to the facility on [DATE] with the following diagnoses:1. Displaced intertrochanteric fracture of right femur2. Chronic respiratory failure with hypoxia3. Collapsed vertebra, lumbar region4. Wedge compression fracture of T11-T12 vertebra5. Gastrostomy status6. Personal history of antineoplastic chemotherapy and irradiation7. Long term (current) use of anticoagulantsK. On 12/14/25 at 2:20 pm, during an interview and observation with R #106 in his room, R #106 was observed to have a feeding pump connected through a tube in his abdomen. R #106 stated he has had a feeding tube since he had cancer eight years ago. L. Record review of R #106's Baseline Care Plan revealed the following:1. The Nursing Services section (Bb of section one) does not indicate that R #106 is a current smoker.2. The Nursing Services section (Cc of section one) does not indicate that R #106 currently takes an anticoagulant.3. The nutritional Services section (section four) does not contain any information.M. On 12/18/25 at 12:00 pm during an interview with the DON, she stated that R #106's Baseline Care Plan does not meet her expectations because it should indicate that he is a current smoker, he currently takes an anticoagulant and uses a feeding tube, but it does not. |

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| F 0657<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>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.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed to ensure staff revised the care plan for 4 (R #2, R #5, R #54, and R #55) of 4 (R #2, R #5, R #54, and R #55) residents reviewed when staff failed to:Revise care plans for R #2 and R #55 for the use of bed rails,Revise care plan for R #5's dependence on staff for bed mobility,Revise care plan to include interventions for bed rail usage for R #54. These deficient practices are likely to result in residents' care and needs not being addressed if care plans are not updated. The findings are: R#2A. Record review of R #2's admission record revealed R #2 was admitted to the facility on [DATE] with the following diagnoses: 1. Morbid obesity (severe degree of being overweight and a significant health concern),2. Muscle weakness (when your muscles cannot work as hard as they should),3. Lack of coordination (difficulty in making controlled purposeful movements),4. Need for assistance with personal care. B. Record review of R #2 care plan revised on 11/11/25 revealed no interventions for the use of bed rails. C. Record review of R #2's Electronic Health Record (EHR), reveals there are no current orders for the use of bedrails. D. On 12/14/25 at 3:49 pm during a random observation of R #2's room revealed quarter size bed rails on the upper left and right sides of the bed. E. On 12/14/25 at 3:50 pm during an interview with R#2, she confirmed she uses the bed rails for positioning and mobility. R#5 F. Record review of R #5's admission record revealed R #5 was admitted into the facility on [DATE] with the following diagnoses:1.Esophagitis, unspecified without bleeding (inflammation of the food pipe where specific cause isn't identified),2. Anxiety Disorder (mental health conditions that cause fear, dread and other symptoms that are out of proportion to the situation),3. Anemia in Chronic kidney disease (complication where kidneys produce less hormones in producing red blood cells leading to fatigue, paleness),4. Muscle weakness, 5. End of stage renal disease (kidneys are severely damaged and can't filter waste effectively),6. Unspecified Systolic (congestive) heart failure (heart can't pump out enough blood throughout the body),7. Fatty liver not elsewhere classified (fat buildup in the liver).G. On 12/15/25 at 9:55 am during an observation of R #5 revealed R #5 was unable to turn and reposition without assistance, quarter size bed rails were noted on both sides of the bed.H. Record review of R #5's Minimum Data Set (MDS) federally mandated clinical assessment tool used in nursing homes to gather demographic and clinical information about residents) dated 12/02/25 revealed R #5 is dependent on staff for bed mobility rolling from left to right. I. Record review of R #5's care plan dated 06/3/24 revealed R #5 can turn and reposition himself in bed without assistance.J. On 12/18/25 at 4:47 pm during an interview with the Director of Nursing (DON), she confirmed R #5's care plan should have been revised to reflect that resident is dependent on staff for repositioning and should have been added to care plan. R #54K. Record review of R #54 admission record revealed she was admitted into the facility on [DATE] with the following diagnoses: 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. Insomnia (a common sleep disorder making it hard to fall asleep, stay asleep),3. Anxiety Disorder (mental health conditions causing intense, excessive, and persistent fear or worry that significantly interferes with daily life),4. Hyperlipidemia (a condition in which there are high levels of fat particles in the blood; high cholesterol),5. Heart failure (impaired heart function). L. Record review of R #54 physician orders revealed an order for quarter size bed rails used for mobility and transfers. Start date 01/09/23. M. Record review of R #54 care plan revised on 11/11/25 revealed no interventions for the use of bed rails. N. On 12/14/25 at 3:55pm during a random observation of R #54's room revealed quarter size bed rails on<br><br>(continued on next page) |

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| F 0657<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | the upper left and right sides of the bed. O. On 12/15/25 at 10:34 am during an interview with R #54's representative, she confirmed she uses the bed rails for positioning and mobility. P. On 12/17/25 at 1:37pm during an interview with the DON, she confirmed R #54's care plan was not revised to include the use of bed rails and should have been. R #55Q. Record review of R #55's admission record revealed R #55 was admitted into the facility on [DATE] with the following diagnoses:1.History of falling,2. Lack of Coordination, 3. Hyperlipidemia, unspecified (high levels of fat in the blood),4. Depression (a mood disorder that causes a persistent feeling of sadness and loss of interest),5. Need for assistance with personal care,6. Chronic Systolic R (congestive) heart failure (heart can't pump out enough blood throughout the body).R. On 12/14/25 at 4:13 pm during a random observation of R #55's room revealed bed rails were in use for R #55.S. Record review of R #55's care plan dated 12/17/25 revealed use of 1/4 bed rails used for bed mobility and transfers.T. On 12/18/25 at 4:48 pm, during an interview with the DON, she confirmed R #55's care plan was not revised prior to 12/17/25 indicating the use of bed rails for bed mobility. |

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| F 0700<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed to ensure residents were assessed for risk of entrapment (state of being stuck or caught on bed rail) in bed rails for 13 (R #2, R #4, R #5, R #6, R #10, R #12, R #13, R #19, R #54, R #55, R #63, R #84, and R #88) of 13 (R #2, R #4, R #5, R #6, R #10, R #12, R #13, R #19, R #54, R #55, R #63, R #84, and R #88) residents reviewed for accidents. This deficient practice has the potential to cause serious injury by becoming trapped between the mattress and bed rail. The findings are: R#2A. Record review of R #2's admission record revealed R #2 was admitted to the facility on [DATE] with the following diagnoses: 1. Morbid obesity (severely overweight),2. Muscle weakness (reduction in the power exerted by muscles),3. Lack of coordination,4. Need for assistance with personal care. B. On 12/14/25 at 3:49 pm during a random observation of R #2's room revealed quarter size bed rails on the upper left and right sides of the bed. C. Record review of R #2's care plan revised on 11/11/25 revealed no interventions for the use of bed rails. D. Record review of R #2's electronic health records revealed the following: 1. There were no physician orders for use of bed rails, 2. There were no assessments completed for R #2 to determine risk of entrapment,3. There were no consents for the use of bed rails prior to installation,4. Documentation of the bed's dimensions was appropriate for the resident's size and weight. E. On 12/14/25 at 3:50 pm during an interview with R #2, she confirmed she uses the bed rails for positioning and mobility. R #4F. Record review of R #4's admission record revealed she was admitted into the facility on [DATE] with the following diagnoses: 1. Schizophrenia (a disorder that affects an individual's ability to think, feel, and behave clearly),2. Dementia (a group of conditions characterized by impairment of at least two brain functions, such as memory loss and judgment),3. Parkinsonism (a general term for movement disorders sharing symptoms with Parkinson's disease),4. Major Depressive Disorder (a mental health disorder characterized by persistently depressed mood or loss of interest in activities, causing significant impairment in daily life),5. Anxiety Disorder (mental health conditions causing intense, excessive, and persistent fear or worry that significantly interferes with daily life). G. Record review of R #4 care plan revised on 06/22/24 revealed R #4 uses quarter size bed rails for mobility and transfers. H. Record review of R #4's electronic health records revealed the following: 1. There were no physician orders for use of bed rails,2. There were no assessments completed for R #4 to determine risk of entrapment,3. There were no consents for the use of bed rails prior to installation,4. Documentation of the bed's dimensions was appropriate for the resident's size and weight. I. On 12/14/25 at 3:52 pm during a random observation of R #4's room revealed quarter size bed rails on the upper left and right sides of the bed. J. On 12/14/25 at 3:53 pm during an interview with R #4, she confirmed she uses the bed rails for positioning and mobility. R#5K. Record review of R #5's admission record revealed R #5 was admitted into the facility on [DATE] with the following diagnoses:1.Esophagitis, unspecified without bleeding (inflammation of the food pipe where specific cause isn't identified),2. Anxiety Disorder, 3. Anemia in Chronic kidney disease (complication where kidneys produce less hormones in producing red blood cells leading to fatigue, paleness),4. Muscle weakness, 5. End of stage renal disease (kidneys are severely damaged and can't filter waste effectively),6. Unspecified Systolic (congestive) heart failure (Heart can't pump out enough blood throughout the body),7. Fatty (change of) liver not elsewhere classified (fat buildup in the liver).L. On 12/15/25 at 9:46 am, during an observation of resident lying in bed, 1/4 side rails were in use and were on both sides of the bed. M.<br><br>(continued on next page) |

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| | 325086 | A. Building<br>B. Wing | 12/18/2025 |

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

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| F 0700<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Record review of R #5's care plan dated 07/29/24 revealed 1/4 assist bars on bed for mobility and transfer. N. Record review of R #5's medical record revealed the record did not contain the following:1. Assessment of the resident for risk of assessment,2. Review of risk and benefits of the bed rails with the resident or resident representative, 3. Consent from the resident or resident representative,4. Documentation of the bed's dimensions was appropriate for the resident's size and weight. R #6O. Record review of R #6's admission record revealed she was admitted into the facility on [DATE] with the following diagnoses: 1. Muscle Wasting Atrophy (the thinning and loss of muscle tissue), 2. Major Depressive Disorder (a mental health disorder characterized by persistently depressed mood or loss of interest in activities, causing significant impairment in daily life)3. Chronic Obstructive Pulmonary Disease (COPD; lung disease) P. Record review of R #6's care plan revised on 10/06/25 revealed R #6 uses quarter size bed rails for mobility and transfers. Q. Record review of R #6's electronic health records revealed the following:1. There were no physician orders for use of bed rails,2. There were no assessments completed for R #6 to determine risk of entrapment,3. There were no consents for the use of bed rails prior to installation,4. Documentation of the bed's dimensions was appropriate for the resident's size and weight. R. On 12/15/25 at 12:19 pm during a random observation of R #6's room revealed quarter size bed rails on the upper left and right sides of the bed. R # 10S. Record review of R #10's admission record revealed R #10 was admitted to the facility on [DATE].T. On 12/14/25 at 12:20 AM, during an observation, R #10's bed had two quarter side rails were in use on both sides of the bed. U. Record review of R #10's physician orders, dated 10/13/25 through 12/14/25, revealed the resident did not have a physician order for bed rails. V. Record review of R #10's baseline care plan dated 10/14/25 revealed staff did not document the residents' use of bedrails. W. Record review of R #10's admission MDS, dated [DATE], revealed R #10 did not use bed rails. X. Record review of R #10's medical record revealed the record did not contain the following:1. Assessment of the resident for risk of assessment,2. Review of risk and benefits of the bed rails with the resident or resident representative, 3. Consent from the resident or resident representative,4. Documentation of the bed's dimensions was appropriate for the resident's size and weight. R #12Y. Record review of R #12's admission record revealed she was admitted into the facility on [DATE] with the following diagnoses: 1. Asthma (a chronic lung condition causing airway inflammation, narrowing, and mucus),2. Muscle weakness (reduction in the power exerted by muscles),3. Difficulty walking. Z. Record review of R #12's care plan revised on 08/28/25 revealed R #12 did not have interventions for the use of bed rails. AA. Record review of R #12's electronic health records revealed the following: 1. There were no physician orders for use of bed rails.2. There were no assessments completed for R #12 to determine risk of entrapment.3. There were no consents for the use of bed rails prior to installation. 4. Documentation of the bed's dimensions was appropriate for the resident's size and weight. BB. On 12/14/25 at 2:48 pm during a random observation of R #12's room revealed quarter size bed rails on the upper left and right sides of the bed.R #13 CC. Record review of R #13's admission record revealed she was admitted into the facility on [DATE] with the following diagnoses: 1. Anxiety (feelings of fear or apprehension),2. Depression (a mood disorder that causes a persistent feeling of sadness and loss of interest),3. Epilepsy (a seizure disorder),4. Muscle Weakness (reduction in the power exerted by muscles). DD. Record review of R #13's care plan revised on 07/08/25 revealed R #13 did not have interventions for the use of bed rails. EE. Record review of R #13's electronic health records revealed the following:1. There were no physician orders for use of bed rails,2. There were no assessments completed for R #13 to determine risk of entrapment,3. There were no consents for the use of bed rails prior to installation, 4. Documentation of the bed's dimensions was appropriate for<br><br>(continued on next page) |

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| F 0700<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | the resident's size and weight. FF. On 12/14/25 at 2:48 pm during a random observation of R #13's room revealed quarter size bed rails on the upper left and right sides of the bed. R#19GG. Record review of R #19's admission record revealed R #19 was admitted into the facility on [DATE] with the following diagnoses: 1. Muscle weakness (generalized),2. Need for assistance with personal care, 3. Spinal Stenosis, cervical region (narrowing of spinal canal in the neck, putting pressure on spinal cord),4. Chronic obstructive pulmonary disease, unspecified (lung disease causing inflammation and damage to airways and air sacs),5. Impetigo, unspecified (high contagious bacterial skin infection causing red sores often around the nose and mouth),6. Other lack of coordination, 7. Hypokalemia (blood potassium levels are low).HH. Record review of R #19's physician order dated 07/09/24 revealed an order for 1/4 assist bars on bed for bed mobility/transfers.II. Record review of R#19's care plan dated 04/12/23 revealed one quarter size side rails used for bed mobility. JJ. Record review of R #19's medical record revealed the record did not contain the following:1. Assessment of the resident for risk of assessment,2. Review of risk and benefits of the bed rails with the resident or resident representative, 3. Consent from the resident or resident representative,4. Documentation of the bed's dimensions was appropriate for the resident's size and weight. R #54KK. Record review of R #54's admission record revealed she was admitted into the facility on [DATE] with the following diagnoses: 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. Insomnia (a common sleep disorder making it hard to fall asleep, stay asleep),3. Anxiety Disorder (mental health conditions causing intense, excessive, and persistent fear or worry that significantly interferes with daily life),4. Hyperlipidemia (a condition in which there are high levels of fat particles in the blood; high cholesterol),5. Heart failure (impaired heart function). LL. Record review of R #54's care plan revised on 11/11/25 revealed no interventions for the use of bed rails. MM. Record review of R #54's physician orders revealed an order for quarter-sized bed rails used for mobility and transfers. Start date 01/09/23. NN. Record review of R #54's electronic health records revealed the following: 1. There were no assessments completed for R #13 to determine risk of entrapment,2. There were no consents for the use of bed rails prior to installation, 3. Documentation of the bed's dimensions was appropriate for the resident's size and weight. OO. On 12/14/25 at 3:55pm during a random observation of R #54's room revealed quarter size bed rails on the upper left and right sides of the bed. PP. On 12/15/25 at 10:34 am during an interview with R #54's representative she confirmed she uses the bed rails for positioning and mobility. R#55QQ. Record review of R #55's admission record revealed R #55 was admitted into the facility on [DATE] with the following diagnoses:1.History of falling, 2. Lack of Coordination, 3. Hyperlipidemia, unspecified (high levels of fat in the blood),4. Depression, unspecified,5. Need for assistance with personal care, 6. Chronic Systolic (congestive) heart failure (heart can't pump out enough blood throughout the body).RR. On 12/14/25 at 4:20 pm, during an observation of R #55's room revealed bed rails on both sides of the bed were in use. SS. Record review of R#55's care plan dated 12/17/25 revealed 1/4 bed rails used for bed mobility but not prior to this date.TT. On 12/14/25 at 12:30 pm, during an interview, R#55 stated he does utilize his bed rails to get in and out of bed. UU. Record review of R #55's medical record revealed the record did not contain the following:1. Assessment of the resident for risk of assessment,2. Review of risk and benefits of the bed rails with the resident or resident representative, 3. Consent from the resident or resident representative,4. Documentation of the bed's dimensions was appropriate for the resident's size and weight. R #63VV. Record review of R #63's admission record revealed R #63 was admitted to the facility on [DATE].WW. On 12/14/25 at 2:28 PM, during an observation, R #63's bed had two quarter<br><br>(continued on next page) |

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| F 0700<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | side rails on both sides of the bed in place. XX. Record review of R #63's physician orders, dated 02/07/25 through 12/14/25, revealed the resident did not have a physician order for bed rails. YY. Record review of R #63's care plan, dated 09/17/25, revealed staff did not document the residents' use of bedrails. ZZ. Record review of R 63's quarterly MDS, dated [DATE], revealed R #63 did not use bed rails. AAA. Record review of R #63's medical record revealed the record did not contain the following:1. Assessment of the resident for risk of assessment,2. Review of risk and benefits of the bed rails with the resident or resident representative, 3. Consent from the resident or resident representative,4. Documentation of the bed's dimensions were appropriate for the resident's size and weight. R #84BBB. Record review of R #84's admission record revealed R #84 was readmitted to the facility on [DATE].CCC. On 12/14/25 at 12:44 PM, during an observation, R #84's bed had two bilateral (relating to two sides) quarter side rails (horizontal metal or plastic bars that extend about a quarter of the length of a bed) in place. DDD. On 12/14/25 at 12:45 PM, during an observation, R #84 used bed rails to adjust her positioning while sitting up in bed.EEE. Record review of R #84's physician orders dated 10/30/25 through 12/14/25, revealed the resident did not have a physician order for bed rails. FFF. Record review of R #84's care plan, dated 10/30/25, revealed bed rails for bed mobility and positioning were not documented.GGG. Record review of R #84 comprehensive Minimum Data Set, dated [DATE], revealed R #84 did not use bed rails.HHH. Record review of R #84's medical record revealed the record did not contain the following:1. Assessment of the resident for risk of assessment,2. Review of risk and benefits of the bed rails with the resident or resident representative, 3. Consent from the resident or resident representative,4. Documentation of the bed's dimensions was appropriate for the resident's size and weight. R #88 III. Record review of R #88's admission record revealed she was admitted into the facility on [DATE] with the following diagnoses: 1. Muscle Weakness (reduction in the power exerted by muscles),2. Lack Of Coordination,3. Muscle Wasting Atrophy (the thinning and loss of muscle tissue).JJJ. Record review of R #88's care plan revised on 07/14/25 revealed interventions for the use of quarter size bed rails to aide in mobility and repositioning. KKK. Record review of R #88's physician orders revealed an order for quarter size bed rails used for mobility and transfers. Start date 01/08/23. LLL. Record review of R #88's electronic health records revealed the following: 1. There were no assessments completed for R #88 to determine risk of entrapment,2. There were no consents for the use of bed rails prior to installation, 3. Documentation of the bed's dimensions was appropriate for the resident's size and weight. MMM. On 12/15/25 at 11:52 am during a random observation of R #88's room revealed quarter size bed rails on the upper left and right sides of the bed. NNN. On 12/15/25 at 11:53 am during an interview with R #88, he confirmed he uses the bed rails for positioning and mobility. OOO. On 12/17/25 at 1:33pm during an interview with the Administrator (ADM), he confirmed there were several residents who were having their bed rails removed due to proper documentation and requirements not being in place. The administrator stated he was working with the DON to identify residents who were not at risk for removal of the bedrails. PPP. On 12/17/25 at 1:37pm during an interview with the DON, she confirmed residents did not have the appropriate requirements for bed rails and were currently being reassessed. She stated that each resident that has bed rails needs to have an assessment/referral completed by therapy, physician orders with indication of use for bed rails, education with consent for residents/representative, and updated care plan. She confirmed this was not done and does not meet her expectations. |

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| F 0732<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Post nurse staffing information every day.<br><br>Based on observation and interview, the facility failed to post nurse staffing data daily at the beginning of the shift that included the following: 1. Facility name. 2. The current date. 3. The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: -Registered nurses. -Licensed practical nurses. -Certified nurse aides. -Resident census. This deficient practice has the potential to affect all 96 residents as identified by the census provided by the Admissions Coordinator (Admit) on 12/14/25 and could likely result in residents and visitors not having the staffing information readily available. The findings are:and visitors not having the staffing information readily available. The findings are:A. On 12/14/25 at 12:15 pm a random observation of the facility revealed the facility's staff data posting was dated 12/11/25.B. On 12/14/25 at 12:32 pm, during an interview with the Admit, she confirmed the staff data posting was for 12/11/25 and had not been updated daily. |

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| F 0757<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Ensure each resident’s drug regimen must be free from unnecessary drugs.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure each resident's drug regimen (plan to manage a person's medication) was free from unnecessary drugs by ensuring indication of use is based on the residents' current diagnosis for 3 (R #2, R #4, and R #54) of 3(R #2, R #4, and R #54) residents reviewed for unnecessary medications. This deficient practice could likely lead to adverse drug effects and poor patient outcomes. The findings are: R #2A. Record review of R #2's admission record revealed she was admitted into the facility on [DATE] with the following diagnoses: 1. Insomnia (a common sleep disorder making it hard to fall asleep, stay asleep),2. Major Depressive Disorder (a mental health disorder characterized by persistently depressed mood or loss of interest in activities, causing significant impairment in daily life),3. Psychotic Disorder (a severe mental illness causing a loss of touch with reality). B. Record review of R #2's physician orders revealed the following:1. Cetirizine hydrochloride (HCl) Oral Tablet 10 milligrams (MG). Give 10 MG by mouth in themorning for seasonal allergies. Start Date 09/12/25.2. Acetaminophen 8 Hour Oral Tablet Extended Release 650 milligrams (MG). Give 1 tablet by mouth two times a day for pain do not administer more than 2000 MG per 24 hours. Start Date 10/30/25. 3. Tramadol hydrochloride (HCl) Oral Tablet 50 milligrams (MG) Give 1 tablet by mouth every 4 hours as needed for pain. Start Date 11/11/25.C. Record review of R #2's Medication Administration Record (MAR) dated December 2025 revealed: 1. R #2 was administered Cetirizine daily from 12/01/25-12/15/25,2. R #2 was administered Acetaminophen two times daily from 12/01/25-12/15/25, 3. R #2 was administered Tramadol as needed on the following dates:1. 12/02/25 at 10:20 am,2. 12/06/25 at 3:00 am,3. 12/10/25 at 3:05 pm,4. 12/10/25 at 9:52 pm,5. 12/13/25 at 7:34 am. D. On 12/18/25 at 12:10 pm during an interview with the Director of Nursing (DON), she confirmed R #2 does not have diagnoses of seasonal allergies nor pain. R #2's medication regimen does not meet her expectations because the indication of use for the medications, Cetirizine, Acetaminophen and Tramadol does not reflect R #2's current diagnoses or indicate treating a symptom of R #2's current diagnoses as she would expect. R #4E. Record review of R #4's admission record revealed she was admitted into the facility on [DATE] with the following diagnoses: 1. Schizophrenia (a disorder that affects an individual's ability to think, feel, and behave clearly),2. Dementia (a group of conditions characterized by impairment of at least two brain functions, such as memory loss and judgment),3. Parkinsonism (a general term for movement disorders sharing symptoms with Parkinson's disease),4. Major Depressive Disorder (a mental health disorder characterized by persistently depressed mood or loss of interest in activities, causing significant impairment in daily life),5. Anxiety Disorder (mental health conditions causing intense, excessive, and persistent fear or worry that significantly interferes with daily life).F. Record review of R #4's physician orders revealed an order for Methotrexate Sodium Oral (a medication used as chemotherapy or immune system suppressant) Tablet 15 MG. Give 15 mg by mouth one time a day every Saturday for Rheumatoid Arthritis (RA; a disease where the immune system mistakenly attacks the joint lining). Start date 10/02/25. G. Record review of R #4's Medication Administration Record (MAR) dated December 2025 revealed R #4 was administered Methotrexate on the following dates:1. 12/07/25 at 8:00 am,2. 12/13/25 at 8:00am. H. On 12/18/25 at 12:10 pm during an interview with the Director of Nursing (DON), she confirmed R #4 does not have a diagnosis of RA. She stated R #4's medication regimen does not meet her expectations because the indication of use for Methotrexate does not reflect R #4's current diagnoses or indicate treating a symptom of R #4's current diagnoses as she would expect. R #54I. Record review of R #54's admission record revealed she was admitted into the facility on [DATE] with the following diagnoses: 1. Major Depressive Disorder (a mental health disorder characterized by<br><br>(continued on next page) |

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| F 0757<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | persistently depressed mood or loss of interest in activities, causing significant impairment in daily life),2. Insomnia (a common sleep disorder making it hard to fall asleep, stay asleep),3. Anxiety Disorder (mental health conditions causing intense, excessive, and persistent fear or worry that significantly interferes with daily life),4. Hyperlipidemia (a condition in which there are high levels of fat particles in the blood; high cholesterol),5. Heart failure (impaired heart function). J. Record review of R #54's physician orders revealed an order for Zyrtec (antihistamine; allergy medication) Oral Tablet 10 milligrams (MG). Give 1 tablet via G-Tube (gastrostomy tube; a feeding tube surgically placed into the stomach to provide nutrition, hydration, and medication) one time a day for allergies. Start Date 10/08/24. K. Record review of R #54's Medication Administration Record (MAR) dated December 2025 revealed R #54 was administered Zyrtec daily from 12/01/25-12/15/25. L. On 12/18/25 at 12:10 pm during an interview with the Director of Nursing (DON), she confirmed R #54 does not have a diagnosis of allergies. She stated R #54's medication regimen does not meet her expectations because the indication of use for Zyrtec does not reflect R #54's current diagnoses or indicate treating a symptom of R #54's current diagnoses as she would expect. |

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| F 0759<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure medication error rates are not 5 percent or greater.<br><br>Based on observation, interview and record review, the facility failed to ensure the medication error rate did not exceed 5 percent (%) when staff performed four medication errors out of 32 opportunities for 1 (R #106) of 6 (R #15, R #35, R #41, R #79, R #101, and R #106) residents reviewed during medication administration. This resulted in a medication error rate of 12.5%. This deficient practice could likely result in the residents receiving incorrect medication, not receiving the desired therapeutic effect, and exposing the residents to a higher risk of side effects. The findings are:A. On 12/17/25 at 8:06 am during an observation of medication administration through R #106's feeding tube, Licensed Vocational Nurse (LVN) #1 prepared [crushing or pouring from a capsule] four different medications for administration and combined all four medications into one medication cup. B. Record review of the facility's policy dated 04/12/23 stated crushed medications are not mixed into the same medicine cup, unless approved by the prescribing physician. C. Record review of physician orders:1. Eliquis 5 mg 1 Tablet via G-Tube,2. Ferrous Sulfate Oral 325mg tablet, give 1 tablet via G-Tube,3. Pantoprazole Sodium oral tablet delayed release, give 1 tablet viat G-Tube,4. Tylenol 325mg, give 2 tablets via G-tube every 6 hours as needed for pain. D. On 12/18/25 at 3:24 PM, during an interview with the Director of Nursing (DON), she stated medications should be prepared in separate medicine cups before administering them through a feeding tube. She confirmed crushed medications should not be combined into one medication cup and this did not meet her expectations. |

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|---|---|
| F 0761<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>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.<br><br>Based on observation and interview, the facility failed to ensure safe medication storage practices by not ensuring the medical supply storage rooms were kept free of expired medications.This deficient practice has the potential to affect all 96 residents as identified by the census provided by the Administrator on 12/14/25. If the facility does not ensure safe storage practices, then residents are at risk for adverse effects due to improper storage. The findings are: A. On 12/18/25 at 10:05 am during an observation of the medical storage, the refrigerator in the storage room revealed the following: 1. One Novolog Mix 70/30 Flex Pen (a pre-filled, disposable insulin pen that combines 70% intermediate-acting insulin aspart protamine and 30% rapid-acting insulin aspart). Expiration date: 03/31/242. Three Novolog Mix 70/30 Flex Pens. Expiration date: 06/30/25.B. On 12/19/25 at 10:07 am during an interview with Licensed Practical Nurse (LPN) #3, she confirmed the pens were expired and should be properly disposed. |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 325086 | A. Building<br>B. Wing | 12/18/2025 |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | 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 complete the following:1. Maintain the ice and water machine in a manner to prevent contamination and foodborne pathogens (a bacterium, virus, or other microorganism that can cause disease), 2. Properly store food items by tracking when to discard, labeling and covering perishable foods, and dating all foods stored in refrigerator, freezer, or pantry.3. Maintain the kitchen environment in a clean and sanitary manner. 4. Temperature tracking sheet on the outside of the refrigerator was dated November 2025. 5. Ensuring food served to residents was sanitary.These failures have the potential to result in cross contamination, the growth of foodborne pathogens, and foodborne illnesses. The findings are:Ice and water machineA. On 12/14/25 at 2:00 pm a random observation of the dining area revealed the ice and water machine had dried residue and what appeared to be dried food particles and splatters covering the outside of the machine and the table the machine sits on.Food storageB. On 12/14/25 at 2:05 pm a random observation of the Resident's fridge located in the satellite kitchen (kitchen area where staff hold and serve meals) revealed the following:1. One case of yogurt with an expiration date of 10/24/25.2. One blueberry yogurt cup with an expiration date of 10/24/25.3. A plastic container with what appeared to be discolored and mushy fruit (strawberries and melon) with no label or date.4. A gallon of milk with an expiration date of 11/26/25.5. A plate of food that appeared to be turkey, mashed potatoes, and stuffing labeled with R #48's name and dated 11/27/25.6. Two aluminum pans that contained a cheese pasta labeled with mac and cheese dated 11/28/25.7. What appeared to be a turkey leg wrapped in plastic wrap and dated 11/28/25.C. On 12/14/25 at 2:35 pm, a random observation of the refrigerator in the satellite kitchen revealed the following:1. Two pitchers that contained an orange liquid with no label or date.2. Two pitchers that contained a red liquid with no label or date.3. One bowl of what appeared to be lettuce, tomato, and onion with no label or date.4. One plastic tub that contained approximately 40 individual plastic containers of what appeared to be mayonnaise with no labels or dates.5. One plastic tub that contained approximately 40 individual plastic containers of what appeared to be Jello with no labels or dates.6. The trashcan located near the hand-washing sink was overflowing with trash to the point where the lid to the trashcan could not close completely.D. On 12/14/25 at 2:40 pm during an interview with the Dietary Aide (DA) #1, she confirmed the items kept resident's refrigerator and the other refrigerator should be labeled and dated and confirmed they were not. DA #1 stated that leftovers (food that is saved) should be thrown out after three days and confirmed the leftovers are old. Clean and sanitary environmentE. On 12/16/25 at 12:00 pm a random observation of the satellite kitchen revealed the wall behind the handwashing sink was covered with what appeared to be dirty, dried food particles, and dried liquid splash marks.F. On 12/14/25 at 2:45 pm a random observation of the main kitchen revealed the following:1. The drain located in the corner of the kitchen was full of what appeared to be food particles and liquid. 2. The food particles and liquid from the corner drain overflowed onto the floor surrounding the drain.3. The floor throughout the kitchen area was dirty with food particles, trash, and spilled liquids.4. The cart where the clean pots and pans are stored was covered in what appeared to be food particles and dried liquid splashes.5. The trash can locate near the food preparation table was overflowing with trash where the lid to the trashcan could not close properly.G. On 12/16/25 at 12:21 pm during an interview with the Regional Nutritionist (RDN), she refused to state whether the kitchen areas met her expectations.Sanitary Food PracticeH. On 12/15/25 at 1:42 PM during a random observation of resident activity, R #101 was seen opening food tray delivery cart sitting in 100 Hall, just after food trays had been delivered. R #101 was seen removing a small bowl of vegetables<br><br>(continued on next page) |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | from the food cart belonging to another resident. R #95 walked up at that time and R #101 asked R #95 to heat up the bowl of vegetables. R #95 took bowl to nurses station and asked staff to warm up the bowl of vegetables. CNA #1 came back with the bowl of vegetables and took it too R #101's room and set it on the bedside table. R #101 was not in the room at that time.I. On 12/15/25 at 1:53 PM, during an interview and observation, CNA #1 was observed carrying bowl of vegetables to R #101's room. During an interview with CNA #1, she stated that R #95 gave her the food and asked her to heat it up for R #101. She admitted that serving R #101 food provided by another resident violated proper sanitary practices. |

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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>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed to maintain proper infection prevention measures for 3(R #6, R #54, and R #98) of 3(R #6, R #54, and R #98) residents reviewed by not: Ensuring Enhanced Barrier Protection (EBP) signage is visibly posted outside resident's room when precautions are in place. Ensuring Personal Protective Equipment is available (PPE) is available,Ensuring EBP signage was posted properly.Infection Control Signs and PPER #6C. Record review of R #6's admission record revealed R #6 was admitted into the facility on [DATE]. D. Record review of R #6's significant change comprehensive assessment dated [DATE] revealed the following:Two, stage three pressure ulcers (involves full-thickness skin loss, where the wound extends through the skin into the fatty tissue), One, stage four pressure ulcer (the most severe type of bedsore, involving full-thickness tissue loss where skin, fat, and underlying muscle, tendon, or bone become exposed and damaged, creating deep, crater-like wounds often with tunneling or undermining and a high risk of serious infection), One, unstageable pressure ulcer (where the wound's depth is hidden by dead tissue) due to non-removable dressing or deviceOne, unstageable pressure ulcer/injury presenting as deep tissue injury (pressure injury often starting at the muscle-bone interface, appearing as purple/maroon intact skin or a blood blister, and can quickly progress to severe wounds despite initial skin appearance). E. On 12/14/25 at 12:17pm during a random observation of the 400-hall revealed the following:1. R #6 did not have EBP (enhanced barrier precaution) sign posted at the entry of his room. 2. R #6 have PPE (personal protective equipment) readily available at the entry of his room.R #54 F. Record review of R #54's admission records revealed R #54 was admitted into the facility on [DATE].G. Record review of R #54's physician orders revealed an order for enteral feeding through gastrostomy tube (G-tube; a tube inserted through the abdomen into the stomach to provide nutrition, fluids, and medication to the body). Start date 12/08/23. H. On 12/14/25 at 12:17pm during a random observation of the 400-hall revealed 1. R #54 did not have EBP (enhanced barrier precaution) sign posted at the entry of her room.2. R #54 have PPE (personal protective equipment) readily available at the entry of her room. R #98I. Record review of R #98's admission records revealed R #98 was admitted into the facility on [DATE].J. Record review of R #98's physician orders revealed an order for Enhanced Barrier precautions due to foley catheter (a flexible tube inserted through the urethra into the bladder to drain urine continuously). Start date 6/24/24 K. On 12/14/25 at 12:17pm during a random observation of the 400-hall revealed R #98 did not have EBP (enhanced barrier precaution) sign posted at the entry of his room.L. On 12/14/25 at 3:59 pm during an interview with Certified Nurse Aide (CNA) #2, she confirmed there was not an EBP sign posted at the entry of R #98's room. M. On 12/18/25 at 12:10 pm during an interview with the Director of Nursing (DON), she confirmed the pressure ulcers, enteral feeding tubes and foley catheters require EBP signs posted outside of the residents' rooms with PPE available for staff. She stated that her expectation is residents with open wounds or indwelling devices should have precautions in place and followed. |

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| F 0909<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | 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.<br><br>Based on observation, record review, and interview, the facility failed to conduct regular inspections of all bed frames, mattresses, and bed rails as part of a regular maintenance program to identify areas of possible entrapment 13 (R #2, R #4, R #5, R #6, R #10, R #12, R #13, R #19, R #54, R #55, R #63, R #84, and R #88) of 13 (R #2, R #4, R #5, R #6, R #10, R #12, R #13, R #19, R #54, R #55, R #63, R #84, and R #88). This deficient practice could likely result in serious injury or death if residents become trapped between the mattress, side rail, footboard and headboard. The findings are: Cross reference findings for 700A. On 12/16/25 at 2:07 pm during an interview with the Director of Nursing (DON) and Administrator (ADMIN), they stated bed evaluations, assessments and regular maintenance should be completed for all residents' beds and they have not been done. They stated this does not meet their expectations for safety. |

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| F 0919<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Make sure that a working call system is available in each resident's bathroom and bathing area.<br><br>Based on observation and interview, the facility failed to ensure call lights in the residents' rooms were within reach of the residents while in the room for 1 (R #5) of 5 (R #2, R #5, R #54, R #88 and R #98) residents reviewed for call lights. This deficient practice could likely result in residents being unable to notify staff when they need assistance. The findings are:A. On 12/15/25 at 9:57am during a random observation of R #5's room, his call light was observed to be on the side of his bed between the mattress and bed rail. B. On 12/15/25 at 9:58 am, during an interview with R #5, he confirmed he could not reach his call light. C. On 12/15/25 am at 10:02 am during an interview with Certified Nurse Aide (CNA) #3, she confirmed R #5's call light was not in his reach and should always be within his reach. |