STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	325087	A. Building B. Wing	05/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Northgate Unit of Lakeview Christian Home	1905 West Pierce Street Carlsbad, NM 88220

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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 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Post nurse staffing information every day. Based on observation, record review and interview, the facility failed to post nurse staffing data daily at the beginning of the shift that included the following:- Facility name.-The current date.-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.1. Registered nurse,2. Licensed practical nurse,3. Certified nurse aides,4. Resident census.The deficient practice has the potential to affect all 77 residents as identified by the census provided by the Administrator (ADM) on 05/17/26 and could likely result in residents and visitors not having the staffing information readily available. The findings are:A. On 05/17/26 at 9:30 am, a random observation of the facility revealed the facility's staff data posting sheet and noted that no staffing data posting sheet was visible in a conspicuous, accessible area. B. Record review of 18 months of staff postings:January 2026: 31 days of postings were reviewed: 31 out of 31 days lacked census documentation.February 2026: 28 days of postings were reviewed; 24 out of 28 days lacked census documentation.C. On 05/21/26 at 8:27 am, during a random observation of the facility revealed the staff data posting sheet was dated for 05/20/26 and the document was not complete. D. On 05/21/26 at 8: 35 am, during an interview, Certified Nurses Aide (CNA) #1 confirmed that the current posted sheet dated 05/20/26 only included the morning shift staffing, and that the resident census was not documented.

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 0761 Level of Harm - Minimal harm or potential for actual harm 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations and interviews, the facility failed to properly store medications and medical supplies located in the facility medication storage room when the staff failed to ensure: -Insulin multidose vials are dated when they are first used and dated 28 days after first use.-Blood collection tubes were not expired.-Lancets (small, sharp, sterile needle used to prick the skin) were not expired.-Hypodermic (under the skin) Injection needles were disposed of after expiration date.-Bluetooth glucose monitoring strips were not expired.-Intravenous (IV; into the vein) catheters were not expired.-Intravenous start kits were not expired.These deficient practices have the potential to affect all 77 residents (as identified by the census provided by the Administrator (ADM) on 05/17/26, resulting in expired medications and medical supplies being used in resident care and could put residents at risk of possible infections and not receiving the full benefits of medications. The findings are:A. On 05/19/26 at 8:10 am, during a random observation of the 200 hall medical storage room, the following items were found to have expired:- 50 lancets expired 02/26,-54 green top blood collection tubes expired on 05/02/25,-74 blue top blood collection tubes expired on 09/01/25,-27 yellow top blood collection tubes expired on 07/01/25,-20 hypodermic needles, 27-gauge (indicates how thickness or thinness of a needle) with safety protection expired on 03/01/26,-22 safety needles, 22-gauge expired 02/20/26,-Two boxes of Bluetooth glucose monitoring strips expired 04/02/26.B. On 05/19/26 at 8:26 am, during an interview with Licensed Practical Nurse (LPN) #1, she confirmed these items were expired and should have been removed from stock.C. On 05/19/24 at 8:33 am, during a random observation of the east medical storage room, the following items were found to have expired:- 23 green top blood collection tubes expired on 01/01/26,- One blue top blood collection tube expired on 03/03/26.- 25 blue top collection tubes expired on 01/01/26,- One multi-use vial of regular insulin found in refrigerator opened without an open date located on box or vial. D. On 05/19/26 at 8:43 am, during an interview with Certified Medication Aide (CMA) #1, she confirmed that an open date and an expiration date was not put on the vial and should have been; she also confirmed the medical supplies had expired and should have been removed from stock.E. On 05/19/26 at 8:40 am, during a random observation of the 400 hall medical storage room, the following items were found to have expired:- One 22 gauge [NAME] Introcan Safety Intravenous (IV; into a vein) catheter expired on 05/01/26,- One 18 gauge IV catheter expired on 12/01/24,- Three 22 gauge IV catheters expired on 01/01/25,- One box of 20 gauge IV catheters expired on 02/01/25,- 11 Excel safety needles, 27 gauge-1.5 inches expired on 03/01/26,- One IV start kit expired on 10/31/25.F. On 05/21/26 at 12:27 pm, during an interview with the Director of Nursing (DON) she stated allowing medical supplies to remain in the working stock does not meet her expectation, she also stated her expectation is to date medications of any type to be labeled and dated according to policy.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, record review, and interview, the facility failed to store and serve food under sanitary conditions when staff failed to ensure:Expired food was disposed of and food items were labeled and dated.Refrigerator temperature logs were not complete.Perform hand hygiene during servingThese deficient practices have the potential to affect all 77 residents as identified by the census provided by the Administrator (ADM) on 05/17/26. If food is not being stored properly and safe food handling practices are not followed then the residents could be at risk of getting foodborne illnesses and becoming ill. The findings are: Expired and unlabeled food stored in the kitchen: A. On 05/17/26 at 10:13 am, an interview and observation of the kitchen revealed the following: Items stored in the refrigerator: 1. One box containing cups of yogurt with an expiration date of 04/17/26. 2. One box containing cups of yogurt with an expiration date of 05/16/26. 3. Two bags of what appeared to be shredded lettuce or shredded cabbage with no label or date. 4. One bag with what appeared to be a sliced red onion with dates of 03/06/26 and 03/25/26 written on it. 5. A gallon of lactose free milk with an expiration date of 05/07/26. 6. A bottle of Italian salad dressing with an expiration date of 01/31/26. B. On 05/17/26 at 10:27 am, during an interview with Dietary Aide (DA) #2, she confirmed the yogurt, bag of lettuce or cabbage, bag of sliced red onion, lactose free milk and the Italian salad dressing were expired and should have been disposed of. Items stored in the freezer: 1. Two bags of what appeared to be frozen chicken with no label or date. 2. Two bags of unidentified frozen meat with no label or date. C. On 05/17/26 at 10:35 am, during an interview with DA #3, she confirmed that the bags of frozen meat were not labeled and dated. DA #3 then placed labels on the bags of frozen meat and put the date of 05/17/26 on the label. D. On 05/20/26 at 10:19 am, an interview and observation of the kitchen revealed one box containing yogurt cups with an expiration date of 05/16/26 in the refrigerator. DA #2 confirmed the yogurt was expired and disposed of it. Cleaning of and Sanitizing of equipment and surfaces: (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	E. On 05/17/26 at 10:13 am, an interview and observation of the kitchen revealed the following: 1. The stove and oven were covered with dried, burnt on food particles and splashes. The stove and oven appeared to be covered in a layer of grease. 2. DA #2 tested the sanitizer bucket, the test proved to be inconclusive. DA #3 confirmed the water in the bucket did not contain the required chemicals needed to sanitize. Refrigerator Logs F. On 05/17/26 at 9:41 am, during a random observation of dining area in the 200 hall, the log on the refrigerator was missing temperature values for 05/02/26, 05/03/26. 05/09/26. 05/10/26, 05/14/26. 05/15/26, 05/16/26, and 05/17/26. G. On 05/17/26 at 9:43 am during an interview with Social Worker (SS) she confirmed that the refrigerator logs were not complete and confirmed the missing dates. H. On 05/17/26 at 10:03 am, during a random observation of the dining are in the 400 hall, the log on the refrigerator was missing temperature values for 05/02/26, 05/03/26, 05/09/26, 05/10/26, 05/16/26, and 05/17/26. I. On 05/17/26 at 10:15 am, during an interview with Certified Nurses Aide (CNA) #2, she confirmed the refrigerator logs were not complete and confirmed the missing dates. Refrigerator Items J. On 05/17/26 at 9:45 am during a random observation of dining area in the 200 hall, the refrigerator in the dining area, there were three pitchers of different colored liquids that were not labeled to identify their contents or adate to indicate when it was made. K. On 05/17/26 at 9:47 am Licensed Practical Nurse (LPN) #1 confirmed the pitchers in the refrigerator were not labeled and dated properly, L. On 05/17/26 at 10:04 am during a random observation of the dining area in the 200 hall, the pitcher labeled apple juice was dated for 05/15/26. M. On 05/17/26 at 10:16 am during an interview with CNA #2, she confirmed the date on the pitcher labeled apple juice was 05/15/26. N. Record review of food storage policy dated 02/24/22 indicated that all products should be dated upon receipt and when they are prepared. O. On 05/17/26 at 11:27 pm, during a random observation and interview, DA #1 confirmed brown liquid that appeared to be tea in a pitcher being served to residents was not labeled or dated. P. On 05/18/26 at 11:20am, during a random observation of dinning, Nurse Aide in Training (NAIT) #2 touched her chair, put a protective covering on R #67 and R #73, then grabbed her chair to sit back down, and began to assist R #67 and R #73 with feeding without preforming hand hygiene. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Q. On 05/18/26 at 11:40 am, during an interview with NAIT #2, she confirmed she should have sanitized what? before assisting R #67 and R #73 with their meal.

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F 0909 Level of Harm - Minimal harm or potential for actual harm 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. Based on record review and interview the facility failed to conduct regular inspections of all bed frames, mattresses, and bed rails, if any, as part of a regular maintenance program to identify areas of possible entrapment. This deficient practice has the potential to affect all 77 residents as identified by the census provided by the Administrator on 05/17/26 and could likely result could likely result in serious injury or death if residents become trapped between the mattress, side rail, footboard and headboard. The findings are: A. Record review of occupational therapy bed inspection form provided by the administrator on 5/20/26 revealed: 1. Inspection of the bed height 2. Inspection of securement of wheelchair cushion. 3. Includes issues identified with bed height and seat cushion. 4. No inspection of frames, mattresses or rails to identify areas of possible entrapment. B. On 05/20/26 at 4:00 pm, during an interview with the Administrator (ADMIN) she confirmed that they do not have a check list or routine maintenance to inspect all bed frames, bed mattresses and bed rails. If they have an issue with bedrails they put in a work order and it is repaired at that time. C. On 05/21/26 at 10:12 am, during an interview with the Maintenance Director (MAINT), he confirmed they do not have a routine maintenance program in place to inspect all bed frames, bed mattresses and bed rails unless a work order is placed.

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F 0924 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Put firmly secured handrails on each side of hallways. Based on observation and interview, the facility failed to maintain corridor handrails for one identified location, this deficiency could compromise safe navigation and support for all 77 residents as identified by the census provided by the Administrator (ADM) on 05/17/26 who use handrails.A. On 05/17/26 at 9:48 am during an observation, a rail along the corridor in west hall just past the main entrance could be easily pulled away from the wall.B. On 05/17/26 at 10:05 am, during an interview with Physical Therapy Assistant (PTA), she confirmed the rail was loose and was easily pulled away from the wall.C. On 05/21/26 at 10:12 am, during an interview with Director of maintenance, he confirmed the rail was loose and needed to be repaired.

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure a resident or their representative were aware of a medication taken by the resident, which included the risks and benefits associated with that medication for 3 (R #18, R #37, and R #56) of 4 (R #8, R #18, R #37, and R #56) residents reviewed for unnecessary medications. If residents and/or their representative are not informed of the risks and benefits of each medication, then they are likely not able to make informed decisions. The findings are: R 18: A. Record review of R #18's Resident Face Sheet revealed she was admitted to the facility on [DATE] with the following diagnoses: 1. Wedge compression fracture of first lumbar vertebra (spinal injury where the front part of the L1 vertebra (the top bone in your lower back) collapses inward, creating a wedge-shaped deformity), 2. Acute pain (starts suddenly and ends when its cause is treated or healed), 3. Chronic diastolic (congestive) heart failure (CHF; impaired heart function), 4. Chronic atrial fibrillation (A-Fib; irregular heart rhythm), 5. Major depressive disorder (MDD; a mental health disorder characterized by persistently depressed mood or loss of interest in activities, causing significant impairment in daily life), 6. Insomnia (common sleep disorder that can make it hard to fall asleep or stay asleep). B. Record review of R #18's physician's orders revealed an order dated 04/17/26 for Sertraline (anti-depressant medication), 50 milligrams (mg) to be given by mouth once a day for depression. C. Record review of R #18's electronic health record (EHR) revealed no consent was present for the Sertraline medication. D. On 05/21/26 at 1:25 pm, during an interview with the Director of Nursing (DON), she confirmed staff did not obtain the consent for the increased dose of the Sertraline. The DON stated this does not meet her expectations because the consent forms are to be obtained prior to the start of the medications and these were not. R 37: E. Record review of R #37's Resident Face Sheet revealed she was admitted to the facility on [DATE] with the following diagnoses: 1. Encephalopathy (a degenerative brain disease that alters brain function or structure), 2. Pneumonia (PNA; infection and inflammation of the lung), (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. Dementia (group of conditions characterized by impairment of at least two brain functions, such as memory loss and judgment), 4. Chronic atrial fibrillation, 5. Major depressive disorder, 6. Generalized anxiety disorder (GAD; feelings of fear or apprehension). F. Record review of R #37's physician's orders revealed the following: 1. An order dated 11/21/24 for Lexapro (anti-depressant medication), 10 mg to be given by mouth once a day for depression. 2. An order dated 01/11/26 for an increase in Lexapro dose from 10 mg to 20 mg to be given by mouth once a day for depression. G. Record review of R #37's EHR revealed no consent was present for the increased dose of Lexapro medication. H. On 05/21/26 at 1:25 pm, during an interview with the DON, she confirmed staff did not obtain the consent for the increased dose of Lexapro. The DON stated this does not meet her expectations because the consent forms are to be obtained prior to the start of the medications and these were not. R #65 I. Record review of R #65's Face Sheet revealed he was admitted to the facility on [DATE] with the following diagnoses: 1. Major depressive disorder, 2. Insomnia, 3. Dementia with mood disturbance, 4. Bipolar disorder (a disorder associated with episodes of mood swings ranging from depressive lows to manic highs), 5. Parkinson's disease (a disorder of the central nervous system that affects movement, often including tremors, difficulty with walking, movement and coordination). J. Record review of R #65's physician order dated 06/27/26 revealed an order for Bupropion (anti-depressant) 150 mg to be given once a day. K. Record review of R #65's EHR revealed no consent was present for the Bupropion. L. On 05/21/26, at 12:54pm, during an interview with the DON she confirmed R #65 did not have a consent prior to the use of Bupropion and should have.

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F 0567 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to manage his or her financial affairs. Based on record review and interview, the facility failed to ensure all residents that have a personal funds account with the facility can access their funds on weekends/evenings. This deficient practice is likely to affect all residents having an account with the facility. If residents are unable to access their funds when desired, then residents are likely to not be able to participate in activities and purchase food or personal items when they choose.A. On 05/19/26 at 9:32 am, during an interview with the Resident Council members [R #8, R #16, R #17, R #25, R #31, R #38, R #39, R #46, R #59, R #65, R #72, R #77, and R #78], they stated that they are not allowed to get money when the front office is closed (evenings and weekends). The residents stated the only way to request money is in advance.B. Record review of the facility's Resident Accounts policy, not dated, revealed the following:1. The person responsible for resident's accounting system is the receptionist.2. The facility will keep an amount of approximately $100 as cash on hand for residents and the remainder of the residents' funds is placed in a checking account at a local bank.C. On 05/20/26 at 3:02 pm, during an interview with the Administrator (ADM) she stated that residents are to request money in advance. The ADM stated that if an emergency happens anytime the office is closed, facility staff will call her or the Business Office Manager and one of them will go to the facility to check money out.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to develop and implement an adequate 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 3 (R #12, R #20, and #58) of 6 (R #2, R #7, #12, R #20, R #58, and #80) residents reviewed for baseline care plans. If the facility fails to develop and implement an adequate baseline care plan within 48 hours of admission for residents, then staff may lack necessary guidance to provide appropriate care which could lead to an adverse event (undesirable experience, preventable or non-preventable, that causes harm to a resident due to medical care or lack of medical care). The findings are:R #12A. Record review of R #12's Face Sheet revealed she was admitted to the facility on [DATE] with the following diagnoses:1. Rheumatoid arthritis (RA; chronic joint disease that causes pain and swelling) with rheumatoid factor (proteins made by the immune system that can attack healthy tissue in the body),2. History of falling,3. Longstanding persistent atrial fibrillation (A-Fib; irregular heart rhythm),4. Chronic pain syndrome,5. Calculus of lower urinary tract (a condition where hard, mineralized deposits (stones) form in the urinary system), 6. Disorder of urinary system.B. Record review of R #12's Baseline Care Plan dated 03/25/26 revealed the form to be blank (containing no information).C. On 05/21/26 at 9:23 am, during an interview with the Director of Nursing (DON), she confirmed that R #12's Baseline Care Plan does not meet her expectations because the form contains no information. R #20D. Record review of R #20's Face Sheet revealed she was admitted to the facility on [DATE] with the following diagnoses:1. Congestive heart failure (CHF; impaired heart function),2. Dementia (a group of conditions characterized by impairment of at least two brain functions, such as memory loss and judgment),3. Osteoarthritis (chronic degeneration of the joint cartilage),4. Type 2 diabetes mellitus (DM2, a condition that results from insufficient production of insulin, causing high blood sugar),5. Chronic kidney disease (CKD; impaired kidney function),6. Major depressive disorder (a mental health disorder characterized by persistently depressed mood or loss of interest in activities, causing significant impairment in daily life),7. Generalized anxiety (feelings of fear or apprehension) disorder,8. History of falling.E. Record review of R #20's electronic health record (EHR) revealed no baseline care plan.F. On 05/21/26 at 9:13 am, during an interview with the DON, she confirmed that the facility failed to develop a baseline care plan for R #20 when she was admitted to the facility. R #58G. Record review of R #58's Face Sheet revealed she was admitted to the facility on [DATE] with the following diagnoses:1. Hemiplegia and hemiparesis (paralysis of the arm, leg, and trunk on the same side of the body) following cerebral infarction (an area of dead tissue in the brain resulting from a blockage or narrowing in the arteries supplying blood and oxygen to the brain) affecting right dominant side,2. Dementia, unspecified severity, with other behavioral disturbance,3. Depression,4. Unspecified open wound on the right foot,5. Chronic pain syndrome,6. Neuromuscular dysfunction of bladder (bladder does not function properly),7. Atrial fibrillation.H. Record review of R #58's EHR revealed no baseline care plan.I. On 05/21/26 at 8:58 am, during an interview with the DON, she confirmed that the facility failed to develop a baseline care plan for R #58 when she was admitted to the facility.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed to maintain an ongoing infection prevention and control program (a program that is used to prevent, recognize, and control the onset and spread of infections) for 3 (R #2, R #17, and R #58) of 6 (R #1, R #2, R #7, R #8, R #17, and R #58) residents reviewed by not:1. Ensuring staff followed proper infection prevention protocols for R #2 who had contact precautions (used for individuals with infections that can spread through direct or indirect contact with the patient or their environment) in place and for R #17 who had enhanced barrier precautions (EBP; an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employs targeted gown and glove use during high contact resident care activities) in place.2. Ensuring EBP was in place and signs were posted outside of R #58's room with personal protective equipment (PPE; protective clothing, face masks, goggles, or other garments or equipment designed to protect the wearer's body from injury or infection) readily available.If the facility fails to maintain an effective infection control program, then infections could spread to residents throughout the facility, resulting in illnesses. The findings are:R #2A. Record review of R #2's Face Sheet revealed he was admitted to the facility on [DATE] and has the following diagnoses:1. Quadriplegia (paralysis of all four limbs),2. Neuromuscular dysfunction of bladder (bladder does not work properly),3. Multiple pressure ulcers (PU; an injury to skin and underlying tissue resulting from prolonged pressure on the skin),4. Methicillin resistant Staphylococcus aureus infection (MRSA; a type of bacteria that is resistant to certain antibiotics),5. Type 2 diabetes mellitus (DM2, a condition that results from insufficient production of insulin, causing high blood sugar).B. On 05/17/26 at 10:30 am, a random observation of R #2's room revealed a sign hanging near his door indicating contact precautions were in place; a cart with drawers of PPE sat next to the door.C. On 05/17/26 at 11:41 am, an observation of R #2's room revealed the following:1. Certified Nurse Aide (CNA) #4 knocked on R #2's door and entered his room. CNA #2 was not wearing any PPE.2. CNA #2 came out of R #2's room a few moments later carrying a metal drink cup with a lid, she walked over to the serving/dining area where other residents were being served or already eating lunch and put ice in the cup, filled the cup up with tea, and microwaved a plate of food. CNA #2 did not wash or sanitize her hands.D. On 05/17/26 at 12:51 pm, during an interview and observation with R #2 in his room, he stated that he understands the reason for needing to be on contact precautions but doesn't mind if staff come in without wearing the gowns. The only trash can in the room was placed next to R #2's tray near his bed. E. On 05/17/26 at 12:55 pm during an interview with CNA #2, she confirmed that all PPE should be discarded in the trash can that is near his bed and then walk across the room to the door to leave.F. On 05/21/26 at 9:23 am, during an interview with the Director of Nursing (DON), she confirmed that contact precautions are in place for R #2. The DON stated that staff are expected to don (put on) PPE prior to entering R #2's room and doff (take off) the used PPE when exiting the room. The DON confirmed that the trash can used to dispose of used PPE should be near the entrance/exit of the room. R #17G. On 05/17/26 at 10:30 am, a random observation of R #17's room revealed a sign hanging near her door indicating EBP was in place and a cart with drawers of PPE sat next to the door.H. Record review of R #17's Face Sheet revealed she was admitted to the facility on [DATE] and has the following diagnoses:1. Non-pressure chronic ulcer (a long-lasting open sore) of skin with necrosis of bone (death of bone tissue),2. Open wound, unspecified lower leg.I. On 05/18/26 at 3:24 pm, an interview and random observation of the facility revealed the following:1. Registered Nurse (RN) #1 knocked on R #17's door and entered the room pulling a vital sign machine (machine used to take vital signs such as blood pressure, pulse, and temperature) without wearing any PPE.2. RN #2 exited R #17's room a few moments later and stated that he was only taking R #17's vital signs, did not touch her wound, so PPE is not required.J. On 05/21/26 at 9:30 am, during an interview with the DON, she confirmed that PPE is required for all care, including taking vital signs, for (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	325087	A. Building B. Wing	05/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Northgate Unit of Lakeview Christian Home	1905 West Pierce Street Carlsbad, NM 88220

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	residents where EBP is in place. R #58K. Record review of R #58's Face Sheet revealed she was admitted to the facility on [DATE] and has the following diagnoses:1. Pressure ulcer, stage 3 (a pressure ulcer with full thickness skin loss that extends into deeper tissue and fat but not into muscle, tendon, or bone) on the foot,2. Unspecified open wound, right foot,L. Record review of R #58's care plan dated 08/28/25 revealed R #58 is at risk for pain and infection due to an open wound. R #58 has a stage 3 pressure ulcer to the right foot.M. On 05/17/26 at 1:36 pm, an observation of R #58's room revealed no signage regarding EBP or PPE was seen outside of R #58's room.N. On 05/15/26 at 10:46 am, during an interview with the DON, she confirmed that R #58 should be on EBP due to her open wound. The DON stated that she expects all residents that have open wounds to be on EBP and confirmed that R #58 was not.

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	325087	A. Building B. Wing	05/21/2026

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Northgate Unit of Lakeview Christian Home	1905 West Pierce Street Carlsbad, NM 88220

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure staff revised the care plan for 1 (R #10) of 2 (R #10 and R #11) residents reviewed when staff failed to update R #10's care plan to include a security alarm bracelet.ˆ This deficient practice is likely to result in residents' care and needs not being addressed if care plans are not updated.ˆ The findings are: A. Record review of R #10's face sheet revealed she was originally admitted to the facility on [DATE] with the following diagnoses:1. Dementia (a group of conditions characterized by impairment of at least two brain functions, such as memory loss and judgment),2. Schizoaffective bipolar type (a mental condition that causes both psychosis and mood problems),3. Depression (a mood disorder that causes a persistent feeling of sadness and loss of interest),4. Bipolar II Disorder (is similar to bipolar I disorder, with moods cycling between high and low over time). B. On 05/18/26 at 10:30 am, an observation of R #10 revealed she had a security alarm bracelet (discreet wearable device tracks movement and triggers automated security responses when a resident nears a restricted area) on her left ankle. C. Record review of physician orders R #10's revealed an order dated on 11/05/24 for a secure alarm bracelet to minimize the risk of elopement. The order was discontinued and renewed on 05/16/26. D. Record review of R #10's quarterly Minimum Data Set (MDS; a federally mandated assessment instrument completed by facility staff) dated 04/10/26, revealed the following:1. A Brief Interview for Mental Status (BIMS; a screening for cognitive impairment) score of six indicating severe impairment.2. R #10 required a wander/elopement alarm. E. Record review of R 10's care plan revised on 04/16/26 revealed R #10 had behavioral problems which included wandering behavior but did not indicate the use of a security alarm bracelet. F. On 05/20/26 at 9:47 am, during an interview Nurse aide in training (NAT) #1 confirmed that R #10 has worn the security guard bracelet for a while and staff will check placement every shift. G. On 05/24/26 at 1:29 pm, during an interview with the Director of Nursing (DON), she confirmed that R #10's security bracelet had not been included in R #10's care plan and should have been.

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	325087	A. Building B. Wing	05/21/2026

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. Based on observation and interview, the facility failed to ensure call lights in residents' rooms were within resident's reach for 1 (R #2) of 4 (R #2, R #7, R #12, R #20) 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 05/17/26 at 12:51 pm, during an interview and observation with R #2 in his room, R #2 was attempting to activate his call light and could not get it activated. R #2 stated that he likes the tap activated call light because it is easier for him to use.B. On 05/17/26 at 12:55 pm, during an interview with Certified Nurse Aide (CNA) #4, she could not activate the call light until she raised the position of R #2's bed. CNA #4 confirmed that the cord to R #2's call light was pinched between the bed and was stopping the call light from working.