STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	325091	A. Building B. Wing	08/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Silver City Care Center	3514 Fowler Avenue Silver City, NM 88061

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0657 Level of Harm - Minimal harm or potential for actual harm 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure care plan revisions occurred for 2 (R #3 and R #8) of 6 (R #1, R #2, R #3, R #4, R #8, and R #9) residents reviewed for care plan accuracy when the staff failed to revise the care plan with the most current resident information. This deficient practice could likely result in the care plan not being updated with the most current resident conditions and appropriate interventions, staff being unaware of changes in care provided, and residents not receiving the care related to changes in their health status or healthcare decisions. The findings are: R #3 A. Record review of R #3’s admission record (no date) revealed R #3 was admitted to the facility on [DATE]. B. Record review of R #3’s progress notes revealed the following: 1. Nurse note dated 05/06/25 at 6:12 PM: “Guardian in to visit with resident. Resident voiced concerns of wanting to go home or possible assisted living. Guardian stated she educated resident that it is a process and will assist in process for resident.” 2. Care plan meeting note dated 07/02/25 at 1:47 PM: “Plan is to move to assisted living in Las [NAME].” C. Record review of R #3’s care plan dated 07/02/24 revealed the following: Focus: R #3 is not expected to be discharged related to inability to care for self at home. Goal: R #3 will be accepting of and appropriate for long-term placement through next review. Interventions: (actions taken by facility staff): Identify, discuss and document resident/patient desires and concerns/barriers regarding discharge. D. On 08/27/25 at 4:32 PM, during an interview with the DON, the following was confirmed: 1. R #3 expressed the desire to be discharged from the nursing facility to an assisted living facility. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. R #3’s care plan was not updated to reflect the change in his discharge plan. R #8 E. Record review of R #8’s admission documents, no date, revealed she was admitted to the facility on [DATE]. F. Record review of R #8's physician's orders, multiple dates, revealed the following: 1. An order dated 06/10/25, for trazodone (prescription antidepressant medication that belongs to the class of drugs known as serotonin antagonist and reuptake inhibitors) 100 mg 1 tablet by mouth once a day for circadian rhythm disorder (a sleep disorder that occurs when your body's internal clock, known as the circadian rhythm, is out of sync with your environment or your desired schedule). 2. An order dated 07/15/25, for mirtazapine (is an atypical tetracyclic antidepressant used primarily to treat major depressive disorder) 15 mg give one tablet at bedtime for depression. G. Record review of R #8’s care plan, dated 07/08/25, revealed the care plan did not contain any interventions or goals for trazadone or mirtazapine. H. On 08/26/25 at 1:39 PM, during an interview, the DON confirmed R #8’s care plan did not have interventions or goals for R #8’s trazodone or mirtazapine. The DON stated her expectation is that there should be interventions and goals for all psychotropic medications.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview, and observation the facility failed to provide activities of daily living (ADL; activities related to personal care such as bathing, showering, dressing, walking, toileting, and eating) assistance for 1 (R #1) of 1 (R #1) resident reviewed for ADL care when staff failed to cut R #1's fingernails. This deficient practice is likely to negatively affect the dignity and health of the residents. The findings are: A. Record review of R #1's admission record, no date, revealed R #1 was admitted to the facility on [DATE]. B. On 08/25/25 at 1:16 PM, during an observation, some of R #1's fingernails were overgrown, some were jagged and uneven from breaking off. C. On 08/25/25 at 1:16 PM, during an interview, R #1 stated staff had not offered to cut her fingernails. R #1 said she did not have any clippers to cut them herself. D. Record review R #1's Quarterly MDS dated [DATE] revealed R #1 needs partial to moderate assistance with personal hygiene. E. On 08/25/25 at 2:25 PM, during an interview, CNA #8 confirmed R #1's fingernails were long and had not been cut.

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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 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate foot care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed to provide foot care for 1 (R #1) of 1 (R #1) resident reviewed for foot care when staff failed to provide nail care for R #1's toenails or make an appointment to a podiatrist for foot care. This deficient practice could likely cause podiatric complications (foot and ankle health issues, often arising from underlying systemic diseases like diabetes or poor circulation, that can lead to problems such as ulcers, infections, nerve damage (neuropathy), and, in severe cases, amputation in residents with diabetes). The findings are: A. Record review of R #1's admission record, no date, revealed the following: 1. R #1 was admitted to the facility on [DATE]. 2. R #1 has a diagnosis of type 2 diabetes mellitus (a chronic metabolic condition characterized by insulin resistance, where the body's cells don't respond to insulin properly, and a gradual decline in the pancreas's ability to produce enough insulin) without complications. B. On 08/25/25 at 1:16 PM, during an observation, R #1's toenails were overgrown, and her feet were callused (a thickened and hardened part of the skin or soft tissue). C. On 08/25/25 at 1:16 PM, during an interview, R #1 stated staff had not offered to cut her toenails and that she had not seen a podiatrist (a person who treats the feet and their ailments) since her admission. R #1 stated she had lost a toenail but that it was growing back. D. Record review of R #1's progress note, dated 07/11/25, revealed R #1 resident's nail fell off with no pain or blood. There was a recommendation from the provider to cleanse with wound cleanser pat dry apply triple antibiotic ointment, cover with dry gauze and secure with tape until healed. E. On 08/25/25 at 2:25 PM, during an interview, CNA #8 confirmed R #1's toenails were long and had not been cut. F. On 08/25/25 at 2:29 PM, during an interview, LPN #8 confirmed R #1 had a diagnosis of type 2 diabetes mellitus. LPN #8 stated that if a resident has a diagnosis of diabetes that a podiatrist will provide foot care for residents. LPN #8 stated the facility does not have a podiatrist that comes to the facility. G. On 08/25/25 at 3:31 PM, during an interview, RN #8 stated she had not seen R #1's toenails and that she had not made any referrals for R #1 to be seen by a podiatrist. RN #8 stated that residents' nails should be checked once a week. RN #8 confirmed R #1 is a diabetic. RN #8 confirmed that R #1's toenails are long and callused. H. On 08/26/25 at 2:46 PM, during an interview, the Schedular (staff who schedules appointments) stated he had scheduled an appointment last week for R #1 to see a podiatrist.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure medical records were complete and accurate for 2 (R #1 and R #8) of 6 (R #1, R #2, R #3, R #4, R #8 and R #9) residents reviewed for documentation accuracy when staff failed to: 1. Document blood pressure and heart rate readings for R #1. 2. Document the correct diagnosis on the medication administration record for R #8. This deficient practice has the potential to have a negative impact on the care staff provide to residents due to missing or inaccurate records and resident information. The findings are: R #1 A. Record review of R #1's admission record (no date) revealed the following: 1. R #1 was admitted to the facility on [DATE]. 2. R #1 diagnoses included: a. Essential primary hypertension (HTN, abnormally high blood pressure that is often influenced by lifestyle factors and not the result of a medical condition). b. Paroxysmal atrial fibrillation (A FIB, episodes of rapid and irregular heartbeats that can last from a few minutes to several days). B. Record review or R #1’s Physicians orders revealed the following: 1. Order dated 01/20/25; metoprolol (medication used to treat blood pressure) 25 mg give half tablet by mouth one time a day for HTN/A FIB, hold (do not give medication) for systolic blood pressure (SBP, top number of blood pressure reading) less than 100, diastolic blood pressure (DBP, bottom number of blood pressure reading) less than 50 or heart rate less than 60. 2. Order dated 03/18/25; lisinopril (medication used to treat high blood pressure) give 30 mg by mouth one time a day for hypertension hold for SBP less than 100 or DBP less than 50. 3. Order dated 07/20 25; furosemide (diuretic medication that helps the body get rid of excess fluid) give 20 mg by mouth one time a day for lower extremity edema (swelling of the legs) hold SBP less than 100 or DBP less than 50 C. Record review of R #1's MAR dated August 2025, revealed the following: 1. Staff did not document R #1’s blood pressure or heart rate when administering metoprolol. 2. Staff did not document R #1’s blood pressure when administering lisinopril. 3. Staff did not document R #1’s blood pressure when administering furosemide. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	D. Record review of R #1’s vital signs (measurements of basic functions of the body that are essential for life including blood pressure, heart rate, body temperature and respiratory rate) for August 2025 revealed the following: 1. Staff did not document R #1’s blood pressure on August 6th, 7th, 14th, 15th, 16th, 17th, 19th, 20th, 21st, 22nd, 23rd and 24th. 2. Staff did not document R #1’s heart rate on August 4th, 6th, 7th, 14th, 15th, 16th, 17th, 19th, 20th, 21st, 22nd, 23rd and 24th. E. On 08/27/25 at 4:22 PM, during an interview with the DON, the following was confirmed: 1. Staff should document the required vital signs when administering medications if the MAR has that option. 2. If staff do not have the option to document vital signs on the MAR they should document them in the vital signs section of the resident’s medical record. 3. Her expectation is that staff will document the vital signs in the medical record as indicated on the physician’s orders. R #8 F. Record review of R #8’s admission documents, no date, revealed she was admitted to the facility on [DATE] with a diagnosis of circadian rhythm sleep disorder. G. Record review of R #8's MAR for the month of August 2025 revealed, mirtazapine 15 mg give one tablet at bedtime for depression. H. Record review of a psychiatric provider progress note, dated 07/15/25, revealed mirtazapine was prescribed for circadian rhythm disorder (a sleep disorder that occurs when your body's internal clock, known as the circadian rhythm, is out of sync with your environment or your desired schedule). I. On 08/26/25 at 1:39 PM, during an interview, the DON stated R #8’s prescription for mirtazapine is for circadian rhythm disorder and that depression is the indication. The DON stated that staff entered the order wrong.