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	11/07/2025

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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. Based on observation and interview, the facility failed to safeguard resident's personal privacy and medical record information for 3 (R #12, R #13 and R #24) of 3 (R #12, R #13 and R #24) residents sampled for privacy and confidentiality of records when the facility failed to do the following: 1. Repair the privacy curtain between R #12 and R #13's room. 2. Keep resident's vital signs and name confidential for R #24. These deficient practices could likely result in the residents feeling that their privacy is not valued and their information could be viewed by unauthorized residents, visitors, and staff. The findings are: A. On 11/05/25 at 10:03 AM, during an observation of R #12 and R #13's room, the privacy curtain had a section that was off track, leaving an open gap at the top of the curtain. B. On 11/06/25 at 10:06 AM, during an interview, Nurse Aide (NA) confirmed the privacy curtain in R #12 and R #13's room was off track and not completely closed. The NA stated that the curtain had been like that for several months. C. On 11/06/25 at 11:12 am, during an interview, LPN #8 confirmed the privacy curtain was off the track. LPN #8 stated that it had been off the track for a couple of months. D. On 11/05/25 at 11:17 AM, during an observation of the 100 Unit outside of R #24's room, a paper towel with R #24's name and vital signs was found on a wheelchair and staff were not present. E. On 11/05/25 at 11:20 AM, during an interview LPN #25 stated R #24's private information should not be exposed in the hallway for everyone to see. R #24 F. On 11/05/25 at 11:17 AM, during observation of the 100 Unit outside of R #24's room, a paper towel with R #24's name and vital signs was found on a wheelchair and staff were not present. G. On 11/05/25 at 11:20 AM, during an interview LPN #25 stated R #24's private information should not be exposed in the hallway for everyone to see. H. On 11/10/25 at 10:51 AM, during an interview with the DON, she confirmed that resident name and vital signs should not be written on a paper towel. DON stated there is a vital sheet that is covered and protected that is used by staff to protect residents' privacy.

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observation, and interview, the facility failed to maintain proper infection prevention measures when staff failed to ensure facility staff follow transmission-based precautions (actions to prevent the spread of infectious agents from individuals who are suspected to be infected, such as (gloves, facemasks, and gowns) for residents diagnosed with COVID-19 (an acute respiratory disease in humans characterized mainly by fever and cough and capable of progressing to severe symptoms and in some cases death, especially in older people and those with underlying health conditions) for 1(R #24) of 1(R #24) resident reviewed. Failure to adhere to an infection control program could likely cause the spread of infections and illness to all 72 residents in the facility (residents were identified by the resident census provided by the administrator on 11/05/25) when staff failed to properly dispose of a disposable isolation gown. The findings are: A. Record review of R #24's face sheet, no date revealed R #24 was admitted to the facility on [DATE]. B. On 11/05/25 at 11:17 AM, during an observation of the 100 unit outside of R #24's room, a yellow disposable gown was left hanging on rail in hallway and a sign posted outside the room which indicated the room was under droplet/covid precautions, (is infection control measures designed to prevent the spread of infectious diseases), and staff should wear N95 mask, (respirators and surgical masks are examples of personal protective equipment that are used to protect the wearer from particles or from liquid contaminating the face) gown, and face shield or goggles to enter. C. On 11/05/25 at 11:17 AM, during an interview with LPN #25, she stated R #24 was positive for COVID. The gown should not be hanging on the rails exposed. LPN #25 stated it should be disposed of after it is used and thrown away in the bin. D. On 11/10/25 at 10:51 AM, during an interview with the DON, she stated that gowns, gloves, goggles, and N95 masks are to be worn in resident room when on precautions for COVID. R #24 was isolated to his room for 14 days when R #24 contracted COVID here at the facility when he returned for the hospital. DON stated her expectation is that staff follow infection control and remove their PPE inside of residents' room before exiting to main hall.

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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 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Keep all essential equipment working safely. Based on observation and interview, the facility failed to ensure the griddle, essential equipment (vitally important; absolutely necessary) was in safe operating condition for 69 residents of 72 residents who eat food from the kitchen (residents were identified by the resident matrix provided by the Administrator on 11/05/25) when the facility failed to ensure the kitchen griddle had knobs to control the gas burners. If knobs are not in working order, then it could likely affect temperature range, making it difficult or impossible to adjust the heat. The findings are:A. On 11/05/25 at 1:58 PM, during an observation of the facility kitchen revealed four out of four knobs on the gas griddle were missing. B. On 11/05/25 at 2:02 PM, during an interview, the Dietary Manager (DM) confirmed that the knobs were missing.