

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

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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 325091	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/10/2026
NAME OF PROVIDER OR SUPPLIER Silver City Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to meet professional standards of practice for 1 (R #1) of 3 (R #1, R #2 and R #3) residents reviewed for insulin (injectable medication used to help lower blood glucose levels) administration, when staff failed to administer insulin as ordered by the provider. This deficient practice could likely lead to uncontrolled blood glucose levels (BGL) or worsening of medical conditions. The findings are: A. Record review of R #1's Face Sheet, no date, revealed the following: 1. R #1 was admitted to the facility on [DATE]. 2. R #1 had a diagnosis of diabetes mellitus (a condition defined by persistently high levels of sugar [glucose] in the blood) B. Record review of R #1's physicians' orders revealed an order dated 12/30/25: Novolin 70/30 (a man-made insulin designed to help manage blood glucose levels by combining 70% longer acting insulin with 30% regular insulin which acts quickly to reduce blood sugar, the combination allows for both immediate and sustained blood glucose control) FlexPen (a compact, pre-filled insulin delivery device) inject 44 units subcutaneously (given just under the skin) in the morning for diabetes mellitus. C. Record review of R #1's MAR dated January 2026, revealed the following: 1. 01/03/26 R #1's BGL was 112 and a partial dose (PD) of Novolin 70/30 was given. 2. 01/04/26 R #1's BGL was 144 and a PD of Novolin 70/30 was given. D. Record review of R #1's MAR dated February 2026, revealed the following: 1. 02/19/26 R #1's BGL was 177 and Novolin 70/30 was held (HD: not given). 2. 02/22/26 R #1's BGL was 86 staff documented within range (WR=blood sugar within range and no insulin given). 3. 02/25/26 R #1's BGL was 74 and Novolin 70/30 was held. 4. 02/26/26 R #1's BGL was 150 and Novolin 70/30 was not given (NG=Parameters [preset range of blood glucose values used to determine action to be taken] out of range-med not given). E. Record review of R #1's MAR dated March 2026, revealed the following: 1. 03/01/26 R #1's BGL was 86 staff documented WR. 2. 03/03/26 R #1's BGL was 79 and Novolin 70/30 was held. 3. 03/04/26 R #1's BGL was 68 and Novolin 70/30 was not given. F. On 06/10/26 at 12:02 PM, during an interview, Nurse Practitioner #1 stated the following: 1. Nursing staff should administer the insulin if there are no hold parameters included in the order. 2. Partial doses of insulin should not be given without discussing with the facility or on-call provider. 3. Nursing staff should contact the provider, either at the facility or the on-call provider that is available 24 hours a day, 7 days a week if there is a concern regarding a residents' BGL and insulin order.		

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, and interview, the facility failed to notify the provider when insulin was not administered as ordered for 1 (R #1) of 3 (R #1, R #2, and R #3) residents reviewed for insulin (injectable medication used to help lower blood glucose levels) administration. This deficient practice could likely lead to uncontrolled blood glucose levels (BGL), result in residents not receiving necessary care, or worsening of medical conditions. The findings are: A. Record review of R #1's Face Sheet, no date, revealed the following: 1. R #1 was admitted to the facility on [DATE]. 2. R #1 had a diagnosis of diabetes mellitus (DM a condition defined by persistently high levels of sugar [glucose] in the blood) B. Record review of R #1's physicians' orders revealed the following: 1. an order dated 12/30/25: Novolin 70/30 (a man-made insulin designed to help manage blood glucose levels by combining 70% longer acting insulin with 30% regular insulin which acts quickly to reduce blood sugar, the combination allows for both immediate and sustained blood glucose control) FlexPen (a compact, pre-filled insulin delivery device) inject 44 units subcutaneously (given just under the skin) in the morning for diabetes mellitus. 2. An order dated 12/08/25: NovoLog injection solution inject as per sliding scale (a method used to adjust insulin doses based on blood glucose levels) subcutaneously before meals and at bedtime for DM: if BGL is 0 - 110 = give 0 units; if 111 - 150 = give 0 units; if 151 - 200 = give 2 units; if 201 - 250 = give 4 units; if 251 - 300 = give 6 units; if 301 - 350 = give 8 units; if 351 - 400 = give 10 units; if 401 - 450 = give 12 units, contact provider if BGL is greater than 451. C. Record review of R #1's MAR dated January 2026, revealed the following: 1. 01/03/26 R #1's BGL was 112 and a partial dose (PD) of Novolin 70/30 was given. 2. 01/04/26 R #1's BGL was 144 and a PD of Novolin 70/30 was given. 3. 01/09/26 at 6:30 AM R #1's BGL was 278, R #1 refused her NovoLog sliding scale insulin. D. Record review of R #1's MAR dated February 2026, revealed the following: 1. 02/19/26 R #1's BGL was 177 and Novolin 70/30 was held (HD: not given). 2. 02/22/26 R #1's BGL was 86 staff documented within range (WR=blood sugar within range and no insulin given). 3. 02/25/26 R #1's BGL was 74 and Novolin 70/30 was held. 4. 02/26/26 R #1's BGL was 150 and Novolin 70/30 was not given (NG=Parameters [preset range of blood glucose values used to determine action to be taken] out of range-med not given). E. Record review of R #1's MAR dated March 2026, revealed the following: 1. 03/01/26 R #1's BGL was 86 staff documented WR. 2. 03/03/26 R #1's BGL was 79 and Novolin 70/30 was held. 3. 03/04/26 R #1's BGL was 68 and Novolin 70/30 was not given. 4. 03/10/26 at 8:00 AM R #1's BGL was 153, staff documented WR blood sugar within range and no insulin given. F. On 06/10/26 at 12:02 PM, during an interview, Nurse Practitioner #1 stated the following: 1. Nursing staff should contact the facility provider or the on-call provider when residents are requesting partial doses of their insulin to determine the course of action and nursing staff should not take it upon themselves to give a partial dose of insulin. 2. Nursing staff should administer the insulin if there are no hold parameters included in the order. 3. Nursing staff should communicate with the facility providers or on-call providers when residents refuse their insulin. 4. Nursing staff should administer sliding scale insulin as ordered.		