STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	325092	A. Building B. Wing	05/14/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
New Mexico State Veterans Home	992 South Broadway Truth OR Consequences, NM 87901

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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 0742 Level of Harm - Actual harm Residents Affected - Some	Provide the appropriate treatment and services to a resident who displays or is diagnosed with mental disorder or psychosocial adjustment difficulty, or who has a history of trauma and/or post-traumatic stress disorder. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure residents with diagnosed mental health disorders, psychosocial distress, and/or suicidal ideation received appropriate behavioral health treatment and services for 3 (R #5, R #89, and R #131) of 4 (R #5, R #9, R #89, and R #131) residents reviewed for behavioral-emotional health, when the facility failed to provide or obtain psychotherapy/counseling for R #5 and R #131; failed to notify the Psychiatric Mental Health Nurse Practitioner (PMHNP) of R #89's hallucinations; and failed to follow through with psychiatric referral/consultation for R #131.The facility's failure resulted in residents' identified mental health needs remaining unaddressed while residents continued to express psychosocial distress, depression, and suicidal ideation, and placed residents at risk for not attaining or maintaining their highest practicable mental and psychosocial well-being. The findings are:R #5 A. Record review of R #5's admission record, no date, revealed the following: 1. An admission date of 11/21/24. 2. The following diagnoses: a. Post traumatic stress disorder (PTSD; a mental health condition triggered by experiencing or witnessing terrifying, life-threatening events). b. Major depressive disorder (a serious mental health condition characterized by persistent low mood, loss of interest, and fatigue which last at least two weeks). c. Anxiety disorder (excessive, persistent, and uncontrollable fear, worry, or dread that interferes with daily life). B. Record review of R #5's Psychotropic Evaluation, dated 10/23/25, revealed the non-pharmacologic care provided to R #5 was music and psychotherapy. The record did not contain any other psychotropic evaluations. C. Record review of R #5's care plan, revision date 01/06/26, revealed R #5 had a diagnosis of PSTD. R #5 had the potential to plan on ending his life because of the pain he was in. R #5 did not want to continue. Refer to psychiatry (the branch of medicine focused on diagnosing, treating, and preventing mental, emotional, and behavioral disorders) and or psychology as indicated. D. Record review of R #5's staff progress notes revealed the following: (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 0742 Level of Harm - Actual harm Residents Affected - Some	1. Dated 01/06/26, R #5 stated he was struggling with pain and does not want to carry on. Staff will schedule an appointment with psych, so he can talk about his depression and suicidal thoughts. Staff will get him scheduled for a psych evaluation. 2. Dated 02/11/26, R #5 cried during a visit with the Chaplain, because he was tired of being in pain and in his bed. The Chaplain encouraged him to get out of bed more so he could enjoy life outside. The Chaplain prayed for R #5. E. On 04/16/26 at 9:07 AM, during an interview, R #5 stated he was very depressed and did not want to go on. R #5 stated staff offered counseling and he accepted. He stated no one ever showed up for the counseling sessions. R #5 stated the Chaplain occasionally visited with him, but the Chaplain was not qualified or useful for the help he needed. R #5 stated he needed help processing his life. R #5 stated he needed a good psychiatric therapist to help him process his feelings and what he has been through. R #5 stated he needed someone trained in PTSD. R #5 stated he has not had any counseling or therapy to help him. R #5 stated staff knew he was depressed, had suicidal thoughts and PTSD. F. On 04/16/26 at 9:16 AM, during an interview, the Chaplain stated he talked to R #5 for spiritual and emotional assistance. The Chaplain stated he tried to help the residents that were suicidal and supported them. The Chaplain stated R #5 reported to him that he had suicidal ideation. The Chaplain stated he believed there was a difference between not wanting to live and wanting to kill yourself. The Chaplain stated he believed R #5 did not want to live because of the pain he was in. The Chaplain stated if he knew a resident was suicidal, then he would report it to his Supervisor. The Chaplain stated he did not have a formal degree in mental health. The Chaplain stated he could diagnose mental health disorders or determine if a resident was considered suicidal. The Chaplain stated he took classes regarding PTSD, but he did not have any formal training for treating residents with PTSD. G. On 04/16/26 at 1:32 PM, during an interview, the Nurse Practitioner (NP) stated she was trained in psychiatric and mental health. The NP confirmed R #5 had depression, PTSD, and suicidal ideation. The NP stated she treated R #5 under the supervision of the Medical Director. The NP stated she and the provider reviewed R #5's medication and treatment when R #5 felt sad or suicidal. She stated they decided if R #5's treatment needed to be adjusted and what medications were best for the resident. The NP stated if R #5 needed therapy, then she provided it. The NP stated if R #5 did not complain of any issues, then she did not provide counseling. The NP stated residents knew how to contact her and could reach out if they needed. The NP stated she did not have consistent counseling sessions with R #5. The NP stated if a resident was suicidal, then they would send them out to the hospital. She stated they did not have the medication to help suicidal residents. The NP stated if she provided counseling services to a resident, then she documented it in the resident's medical record. The NP stated R #5's medical record did not contain any documentation to show she provided counseling to R #5. The NP stated if it was not documented, then it did not happen. H. On 04/16/26 at 2:44 PM, during an interview, R #5 stated the NP did not provide therapy or counseling for him. R #5 stated he needed consistent counseling, not just on bad days. R #5 stated they stayed on top of his antidepressants, but mental health was not just about medication. R #5 stated he needed counseling. I. On 04/16/26 at 4:38 PM, during an interview, R #5's wife stated R #5 used to be very active. R #5's wife stated he struggled with not being able to do what he used to do and with constant pain. R #5's wife stated the facility sent him out to the hospital when R #5 was suicidal. She stated the facility did not provide R #5 any therapy or counseling, other than visits with the Chaplain. R #5's wife thought (continued on next page)

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	325092	A. Building B. Wing	05/14/2026

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F 0742 Level of Harm - Actual harm Residents Affected - Some	discuss updates) every Wednesday, and she was not aware R #89 saw moles. The NP stated she would have discussed R #89's medication with the provider if she was aware the resident saw moles. The NP stated they monitored R #89's medication and made changes, if needed. The NP stated she did not provided counseling for R #89, because he did not state he needed it. The NP stated a mental health assessment was done for R #89 on 01/31/26. She stated the assessment indicated R #89 was not satisfied with his life, he dropped many activities and interest, he was often bored, and he was not in good spirits most of the time. R #131 T. Record review of R #131's admission Record, no date, revealed R #131 was admitted to the facility on [DATE] and discharged from the facility on 02/03/26. R #131 had the following diagnoses: 1. Major depressive disorder (MDD, mood disorder that causes a persistent feeling of sadness and loss of interest). 2. Paranoid schizophrenia (a chronic mental health condition characterized by intense, irrational distrust (paranoia) and symptoms of psychosis, such as delusions and auditory hallucinations, often focusing on themes of persecution). 3. Unspecified dementia (a progressive syndrome caused by abnormal brain changes, resulting in cognitive decline (memory loss, language difficulties, poor reasoning) that interferes with daily life) without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety. 4. Generalized anxiety disorder (GAD, a mental health condition characterized by persistent, excessive, and uncontrollable worry about various daily, routine, or future events for at least 6 months). 5. Suicidal ideations (SI, thinking about, considering, or planning suicide, ranging from fleeting thoughts to detailed plans). U. Record review of R #131's physician's orders revealed the following: 1. Order dated 07/08/25 to send to the emergency room (ER) per resident request. 2. Order dated 08/06/25 for a psychiatry consult. 3. Order dated 09/11/25 to send to ER for psychiatric evaluation. 4. Order dated 11/25/25 to send to local hospital to expedite transfer to psychiatric facility. 5. Order dated 01/28/26 to send to the ER for psychiatric treatment. V. Record review of R #131's nursing progress notes revealed the following: 1. Dated 07/08/25, R #131 called crisis hotline (a free, confidential 24/7 phone or text service providing immediate, trained counselor support for people experiencing acute mental health, emotional, or suicidal distress) stating he was depressed, the treatment at the facility was not working, and he wanted to go to another city to receive treatment. (continued on next page)

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	325092	A. Building B. Wing	05/14/2026

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F 0742 Level of Harm - Actual harm Residents Affected - Some	1. Dated 08/07/25, R #131 said he would be better off dead. R #131's mood was all over the place. R #131 stated he wanted to go to a psychiatric facility. 2. Dated 08/27/25, R #131 requested to be transferred to a psychiatric facility in another state. Stated he felt he was not receiving the appropriate psychiatric care at the facility, and he was satisfied with the care he received at the facility he was requesting to transfer to. The Social Services Worker (SSW) told R #131 the facility could not transfer him to a psychiatric facility, and he would need to go to an acute care setting (Emergency Room) to get a referral to be admitted to a psychiatric facility. 3. Dated 09/04/25, R #131 called the SSW several times and left voice messages. The resident stated he wanted specialty psychiatric care and was convinced he had to go to a specific psychiatric facility in another state. The SSW told R #131 psychiatric hospitals were usually temporary, and R #131 said he thought he could live at a psychiatric facility permanently. The PMHNP saw R #131, but R #131 felt he needed inpatient psychiatric care to receive the appropriate services. 4. Dated 11/07/25, R #131 told the SSW he was depressed and felt like he needed to get out of the facility. R #131 stated he felt like he needed to go to the mental health hospital in [state name] since they understood his mental health problems. 5. Dated 11/10/25, the SSW documented, he stated that he was only existing and not living. R #131 told the SSW the mental health treatment he received at the facility was not working and his previous treatments involved therapy. R #131 requested to see a psychiatrist. 6. Dated 11/13/25 at 10:36 AM, R #131 appeared to be hallucinating about God. R #131 rocked side to side and stated he wanted to get out of the facility. 7. Dated 11/13/25 at 4:36 PM, R #131 told the SSW he was not happy at the facility, because he was not getting the psychiatric care he needed. 8. Dated 11/19/25, R #131 reported being isolated, lonely, and his socialization needs were not met. 9. Dated 01/26/26, R #131 told the SSW he felt he had nothing to live for, but he was not suicidal. Y. Record review of R #131's provider progress notes revealed the following: 1. Dated 07/09/25, the provider documented R #131 had worsening depression, had made suicidal ideation statements, and behavioral issues. R #131 requested to see psychiatry daily. The provider documented the plan for R #131 was to monitor his behaviors and redirect behavior issues appropriately. 2. Dated 08/06/25, the provider documented R #131 was depressed and was taking a lot of psychiatric medications. The plan was to have R #131 evaluated by a psychiatrist. 3. Dated 08/20/25, the provider documented R #131's depression was still present, R #131 did not take his medications as prescribed, and R #131 requested to be transferred to another state to see a psychiatrist. The provider documented the plan for R #131 was to refer him to a local psychiatrist and work on getting him transferred per R #131's wish. (continued on next page)

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	325092	A. Building B. Wing	05/14/2026

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	325092	A. Building B. Wing	05/14/2026

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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 0742 Level of Harm - Actual harm Residents Affected - Some	CC. Record review of R #131's behavioral health hospital discharge documents, dated 10/10/25, revealed if R #131 felt overwhelmed, unable to cope, extremely anxious, or had suicidal ideation or thoughts of wanting to harm someone else, then he was to call his psychiatrist or therapist immediately. DD. Record review of R #131's medical record, no date, revealed staff did not document R #131 was seen by a psychiatrist or psychotherapy notes. EE. On 04/16/26 at 11:23 AM, during an interview, the PMHNP stated the following: 1. She completed weekly rounds with the MD to discuss resident's needs and adjust medications if needed. 2. She did psychotherapy with residents if there was a need. 3. She documented psychotherapy notes in a paper progress note. 4. She would see R #131 if the nurses told her there was a concern or when he would escalate. 5. She did not meet with R #131 on a regular basis, only if an issue would come up. 6. If residents were calm and there were no safety issues, she would only see them for weekly rounds with the MD. 7. She stated there were no concerns with R #131 after he returned from the behavioral health hospital on [DATE]. FF. On 04/16/26 at 1:11 PM, during an interview, the Social Services Director stated the following: 1. He was not aware R #131 was not happy with the psychiatric services provided by the facility. 2. If residents were not happy with the psychiatric services at the facility, then they were able to go to [name of agency in another town]. 3. The facility did not have any social workers trained to do therapy. 4. The only person in the facility qualified to do psychotherapy was the PMHNP. 5. He confirmed R #131's medical record did not have any psychotherapy notes. GG. On 04/16/25 at 2:26 PM, during an interview, the ADON stated the following: 1. The PMHNP did psychotherapy with residents. 2. R #131 voiced not wanting to see the PMHNP and wanted to see a psychiatrist. 3. R #131 voiced not being happy with the psychiatric services he was being provided at the facility. 4. She was not aware the provider ordered for R #131 to be referred to a psychiatrist. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	325092	A. Building B. Wing	05/14/2026

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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 0742 Level of Harm - Actual harm Residents Affected - Some	5. Staff documented psychotherapy was one of R #131's non-pharmacological interventions on R #131's psychotropic evaluation, dated 08/28/25. 6. Psychotherapy was expected to be performed on a regular basis. 7. R #131's medical record only had two progress notes from the PMHNP. 8. R #131's progress notes completed by the PMHNP appeared to be in response to R #131 having suicidal ideation. 9. R #131 was not seen by a psychiatrist. HH. On 04/16/26 at 3:18 PM, during an interview, the Administrator confirmed the following: 1. The facility did not have a psychiatrist. 2. R #131 did not want to see the PMHNP, because he wanted to see a psychiatrist. 3. R #131 voiced not being happy with his psychiatric care. 4.