

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: 325092	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/14/2026
NAME OF PROVIDER OR SUPPLIER New Mexico State Veterans Home		STREET ADDRESS, CITY, STATE, ZIP CODE 992 South Broadway Truth OR Consequences, NM 87901	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
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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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F 0742 Level of Harm - Actual harm Residents Affected - Some	4. Dated 09/10/25, the provider documented R #131 refused treatment and medications. The plan for R #131 was to redirect R #131 and reassure him. 5. Dated 09/19/25, the provider documented R #131 was transferred to the psychiatric hospital due to suicidal ideation. 6. On 10/15/25, the provider documented R #131 was seen and treated by the psychiatric hospital for suicidal ideation. The plan for R #131 was to prescribe new medications, monitor, and redirect R #131. 7. Dated 11/05/25, the provider documented a referral would be placed for R #131 to see VA psych. 8. Dated 11/19/25, the provider documented R #131 still needed to see a psychiatrist. 9. Dated 11/26/25, the provider documented R #131 refused medications, had behavior issues and altered mental status. The plan for R #131 was to consider Depot injectable (antipsychotic medication) for schizophrenia. The provider documented R #131 was on the list to see a psychiatrist. 10. Dated 01/21/26, the provider documented that staff were reporting R #131 had more behavior issues, was talking too much, and his behavior was worse. The plan for R #131 was to increase his psychotropic medication and redirect behavioral issues. 11. The provider did not document any additional progress notes related to R #131's psychiatric conditions. Z. Record review of R #131's PMHNP progress notes revealed the following: 1. Dated 08/07/25, R #131 was seen. Staff notified her that R #131 had suicidal ideation. R #131 stated 1980 was the last time he had a plan to kill himself. Recommended R #131 be sent out for evaluation and treatment. 2. Dated 08/28/25, R #131 expressed suicidal ideation but refused to be sent to the ER. Staff were instructed to monitor R #131 for safety and comfort. 3. The PMHNP did not document any other progress notes for R #131. AA. Record review of R #131's Psychotropic Evaluation, dated 08/28/25, revealed the non-pharmacological interventions for R #131 were constant redirection and psychotherapy (talk therapy, a collaborative treatment based on the relationship between an individual and a trained mental health professional). BB. Record review of R #131's Mental Health Assessments revealed the following: 1. Dated 07/10/25, staff documented R #131 was irritable, not cordial, angry, and his cognition (includes thinking, knowing, remembering, judging, and problem-solving) was mixed up. Staff documented the plan was to monitor R #131 for safety and comfort. 2. Dated 08/08/25, staff documented R #131 was depressed. Staff documented the plan was to monitor R #131 for safety and comfort. (continued on next page)		

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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)		

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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.		

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure residents did not receive psychotropic medications (group of drugs that affect behavior, mood, thoughts, or perception) unless the medication was medically necessary for 2 (R #11, and R #78) of 5 (R #2, R #6, R #11, R #78, and R #124) residents reviewed for unnecessary medications, when staff failed to: 1. Ensure antipsychotic medications (a class of psychotropic medication primarily used to manage psychosis, a mental health symptom involving a loss of contact with reality, characterized by hallucinations, delusions, and disorganized thinking) were prescribed to treat an appropriate psychiatric diagnosis (mental illness, symptoms or condition that greatly disturbs your thinking, moods, and/or behavior) for R #78. 2. Ensure a gradual dose reduction (GDR; stepwise tapering of a dose to determine if symptoms, conditions, or risks can be managed by a lower dose or if the dose or medication can be discontinued) was carried out for R #11, and R #78. These deficient practices could likely result in residents receiving medications without a medical reason and being at a higher risk of adverse side effects (unwanted, undesirable, and often unexpected reactions to medication). The findings are: R #11 A. Record review of R #11's admission Record, no date, revealed the following: 1. R #11 was admitted to the facility on [DATE]. 2. R #11 had the following diagnoses: a. Major depressive disorder, recurrent, moderate (depressive episodes with periods of remission in between moderate severity indicates significant symptoms and functional impairment but not complete disruption of daily life) b. Unspecified psychosis not due to a substance or known physiological condition (is a psychiatric diagnosis used when a person exhibits psychotic symptoms—such as hallucinations, delusions, and disorganized thinking—but the cause cannot be attributed to substance use or a known medical condition). c. Post-traumatic stress disorder, unspecified (PTSD, a mental health condition triggered by experiencing or witnessing terrifying, life-threatening events). B. Record review of R #11's physician orders revealed the following: 1. An order dated 08/28/25 for bupropion (medication used to treat depression) oral tablet extended release 24 Hour give 300 mg by mouth one time a day related to major depressive disorder recurrent, moderate. 2. An order dated 10/25/25 for duloxetine (medication used to treat major depressive disorder and anxiety disorder) HCl oral capsule delayed release. Sprinkle 60 mg (Duloxetine HCl) Give 60 mg by mouth two times a day related to major depressive disorder, recurrent, severe with psychotic symptoms. (continued on next page)		

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. An order dated 08/08/25 for quetiapine fumarate (medication used to treat major depressive disorder by balancing brain chemicals linked to mood and behavior) oral tablet 100 mg 1 tablet by mouth at bedtime related to unspecified psychosis. C. Record review of R #11's Medication Regimen Review, dated 03/30/26, revealed the following: 1. The pharmacist recommended a GDR for R #11's order for bupropion 300 mg xl one time a day. a. The provider selected disagree. Please offer clinical rationale below. b. The provider wrote stable. He did not document a clinical rationale for why a GDR should not be completed for R #11's bupropion 300 mg. 2. The pharmacist recommended a GDR for R #11's order for quetiapine 100 mg 1 tablet at bedtime. a. The provider selected disagree. Please offer clinical rationale below. b. The provider wrote resident is very depressed and unspecified psychosis. He did not document a clinical rationale for why a GDR should not be completed for R #11's quetiapine 100 mg. 3. The pharmacist recommended a GDR for R #11's order for duloxetine 60 mg two times a day. a. The provider selected disagree. Please offer clinical rationale below. b. The provider wrote stable. He did not document a clinical rationale for why a GDR should not be completed for R #11's duloxetine 60 mg. D. Record review of R #11's medical record, no date, revealed: 1. The provider did not document a clinical rationale for why a GDR should not be completed for R #11's bupropion 300 mg after the pharmacist's recommendation on 03/30/26. 2. The provider did not document a clinical rationale for why a GDR should not be completed for R #11's quetiapine 100 mg after the pharmacist's recommendation on 03/30/26. 3. The provider did not document a clinical rationale for why a GDR should not be completed for R #11's duloxetine 60 mg after the pharmacist's recommendation on 03/30/26. E. On 04/21/26 at 1:10 PM, during an interview, House Supervisor (HS) #24 stated the following: 1. The provider was expected to review all pharmacist recommendations. They are to sign the pharmacist recommendation forms for R #11. 2. HS #24 confirmed the provider did not agree with the pharmacist's recommendation. The provider was expected to document a clear clinical rationale for why they did not want to follow the recommendation for R #11's medications duloxetine, bupropion, and quetiapine. R #78 (continued on next page)		

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	F. Record review of R #78's admission Record, no date, revealed the following: 1. R #78 was admitted to the facility on [DATE]. 2. R #78 had the following diagnoses: a. PTSD. b. Vascular dementia, unspecified severity, with other behavioral disturbance (involves cognitive decline caused by brain vascular damage (e.g., strokes), marked by sudden, stepwise changes in personality, mood, and conduct). c. Anxiety disorder (mental health conditions characterized by excessive, uncontrollable, and persistent fear or worry that interferes with daily life, lasting at least six months). d. Sleep disorder (disturb normal sleep patterns, affecting sleep quality, timing, or duration and causing excessive daytime sleepiness or impairment). G. Record review of R #78's physician's orders revealed the following: 1. An order dated 09/17/25, for olanzapine (an atypical antipsychotic medication primarily used to treat schizophrenia and bipolar 1 disorder) 2.5 mg in the morning for unspecified dementia with other behavioral disturbance. 2. A black box warning (the most serious warning the U.S. Food and Drug Administration (FDA) can issue on drug and device labeling, alerting healthcare providers and patients to the risk of death or serious injury associated with the product) attached to the olanzapine 2.5 mg order in the Electronic Medical Record (EMR) system that stated Increased mortality in elderly patients with dementia-related psychosis. Elderly patients with dementia-related psychosis treated with antipsychotic drugs are at an increased risk of death. 3. An order dated 09/17/25, for olanzapine 5 mg at bedtime for dementia with other behavioral disturbance. 4. Another black box warning attached to the olanzapine 5 mg order in the EMR system. 5. An order dated 07/13/25, for trazadone (a serotonin antagonist and reuptake inhibitor ([NAME]) antidepressant primarily used off-label for insomnia due to its strong sedative properties) 50 mg at bedtime for sleep, related to sleep disorder. H. Record review of R #78's Medication Regimen Review, dated 01/20/26, revealed the following: 1. The pharmacist recommended a GDR for R #78's trazadone 50 mg. 2. The provider selected Disagree, please offer clinical rationale below. 3. The provider did not document a clinical rationale for why a GDR should not be attempted for R #78's order for trazadone 50 mg. (continued on next page)		

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	I. Record review of R #78's medical record, no date, revealed the provider did not document a clinical rationale for why a GDR was not conducted for R #78's trazadone. J. On 04/21/26 at 2:07 PM, during an interview, the Registered Nurse Associate Manager confirmed the following: 1. R #78 was receiving the antipsychotic medication olanzapine. R #78 did not have a diagnosis that had symptoms of psychosis. 2. R #78 had been taking trazadone 50 mg since 07/13/25. 3. A GDR had not been attempted for R #78's trazadone 50 mg. 4. The provider did not document in R #78's medical record a clinical rationale for why a GDR was not implemented for R #78's trazadone 50 mg.		

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure the MDS was accurate for 3 (R #1, R #9 and R #133) of 6 (R #1, R #7, R #9, R #112, R #132, and R #133) residents reviewed for accurate MDS assessments. This deficient practice could likely result in the facility not having an accurate assessment of the residents' needs. The findings are: R #1 A. Record review of R #1's admission Record, no date, revealed he was admitted on [DATE]. ^ B. Record review of R #1's nursing progress note, dated 01/25/26, revealed R #1 was transferred to the hospital due to altered mental status (AMS; a broad term describing any change in a person's awareness, cognition, or behavior from their usual baseline, ranging from mild confusion to complete unresponsiveness). ~~~~~ C. Record review of R #1 Convalescent Care Orders (physician orders that authorize a person to receive short-term, skilled care in a nursing facility, or other approved setting while they recover from an illness or acute health event) dated 03/02/26 revealed the following: 1. R #1 diagnosis was urinary tract infection (UTI; infection in any part of the urinary systems which include the kidneys, bladder, ureters and urethra). 2. R #1 had an order for ertapenem (antibiotic used to treat severe infections caused by various bacteria) 1 gram to be given intravenously (given in the vein) once daily for 3 days for UTI. ^ D. Record review of R #1's Significant Change MDS assessment dated [DATE] revealed that staff did not document R #1 had a diagnosis of UTI in the last 30 days. E. On 04/21/26 at 4:43 PM, during an interview, with RN #1 and the MDS Coordinator the following was confirmed: 1. R #1 was treated with antibiotics for a UTI when he returned to the facility on [DATE]. 2. R #1's Significant Change MDS dated [DATE] did not include R #1's UTI diagnosis. R #9 F. Record review of R #9's admission Record, no date, revealed she was readmitted on [DATE]. G. Record review of R #9's wound care consultation progress note dated 11/21/25 revealed the following: 1. Chief Complaint: Follow-up evaluation of chronic stage four (4) (long-standing, severe pressure injury that has persisted for an extended period, often months or years, and involves full-thickness tissue loss with exposed bone, tendon, or muscle) sacral (region of the lower back located just above the tailbone) pressure injury with known osteomyelitis (an infection or inflammation of the bone, usually caused by bacteria which can lead to bone damage if untreated). 2. Assessments (clinician's professional evaluation of a patient's condition, synthesizing symptoms and findings into a diagnosis or clinical impression): Pressure ulcer of sacral region, stage 4. H. Record review of R #9's Significant Change MDS dated [DATE] revealed that staff did not document that R #1 had a diagnosis of a stage 4 pressure ulcer. I. On 04/21/26 at 4:43 PM, during an interview with the MDS Coordinator, she confirmed the following: 1. The wound care doctor did document that R #9 had a stage 4 pressure ulcer on the visit note for 11/21/25. 2. Staff did not include R #9's stage 4 pressure ulcer under the active diagnosis section of R #9's Significant Change MDS dated [DATE]. 3. R #9 does have an active diagnosis of a stage 4 pressure ulcer that should be included on the MDS. R #133 J. Record review of R #133's admission Record, no date, revealed the following: 1. R #133 was admitted on [DATE]. 2. Diagnosis of UTI. ^ K. Record review of R #133's progress notes revealed the following: 1. Provider progress noted dated 02/25/26, revealed the following: Urinalysis (routine examination of the urine for bacteria and chemicals that suggest various illnesses, including infection and kidney disease) reviewed. It showed moderate leukocytes (presence of white blood cells, often signaling an infection or inflammation in the urinary tract) and positive nitrites (strong indicator of bacterial infection, most commonly UTI). Patient has been falling lately. Pending culture and sensitivity (laboratory test that identifies bacteria or fungi in a sample and determines which antibiotics or antifungal medications are effective in treating the infection). I will start empiric antibiotics (prescribed before the exact cause of an infection is identified). Ciprofloxacin (Cipro; antibiotic used to treat a wide range of bacterial infections including urinary tract infections) 500 mg twice a day for 7 days. Review once we have (continued on next page)		

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	culture results. 2. Nursing progress note dated 02/26/26: Resident started on Cipro 500 mg twice a day this shift for UTI. 3. Nursing progress note dated 02/27/26: Continues on oral antibiotics for UTI until 03/05/26. 4. Nursing progress note dated 02/28/26: Resident continues antibiotics for UTI. 5. Nursing progress note dated 03/02/26: Resident continues on Cipro 500 mg twice daily for UTI. L. Record review of R #133's Physician's orders revealed an order dated 02/26/26: Ciprofloxacin oral tablet 500 mg, give 1 tablet by mouth two times a day for UTI. ^ M. Record review of R #133's Quarterly MDS assessment dated [DATE] revealed that staff did not document that R #133 had a diagnosis of UTI in the last 30 days. N. On 04/21/26 at 4:43 PM, during an interview with the MDS Coordinator the following was confirmed: 1. R #133 was treated with antibiotics for a UTI from 02/26/26 through 03/04/26. 2. R #133's Quarterly MDS dated [DATE] did not include R #133's UTI diagnosis.		

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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 and care plan meeting requirements occurred for 9 (R #2, R #4, R #5, R #11, R #18, R #28, R #29, R #92, and R #124) of 9 (R #2, R #4, R #5, R #11, R #18, R #28, R #29, R #92, and R #124) residents reviewed for care plans, when the staff failed to: 1. Ensure the required IDT members attend the care plan meeting, and staff did not document any input from the physician or the CNA who provided care for R #2, R #4, R #5, R #11, R #18, R #28, R #29, and R #92. 2. Ensure the care plan meeting was held within 7 days from the completion of the MDS assessment when creating or revising the care plan for R #4, R #28, and R #29. 3. Revise the care plan with the most current resident information for R #1, R #2, R #5, and R #124. These deficient practices could likely result in care plans not being updated with the most current resident conditions and appropriate interventions, staff being unaware of changes in care being provided, and residents not receiving the care related to changes in their health status or healthcare decisions. The findings are: IDT Members and Timing R #2 A. Record review of R #2's admission Record, no date, revealed an admission date of 01/29/26. B. Record review of R #2's care plan meeting note dated 03/19/26 revealed the following: 1. The IDT did not include the physician and the CNA in the meeting. 2. Staff did not document that they received input from the physician or the CNA who provided care to R #2. C. On 04/15/26 of 3:23 PM, during an interview with the Senior Social Worker (SSW) confirmed the following: 1. R #2 had a care conference on 03/19/26. 2. The CNA, and physician were not present in the meeting. 3. The CNA, and physician did not give input for R #2's care plan meeting. R #4 D. Record review of R #4's admission Record, no date, revealed an admission date of 03/21/24. E. Record review of R #4's annual MDS was completed on 02/18/26. F. Record review of R #4's care plan meeting note dated 02/26/26 revealed the following: 1. The interdisciplinary team did not include the physician and the CNA in the meeting. (continued on next page)		

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. Staff did not document that they received input from the physician or the CNA who provided care to R #4. 3. Care plan meeting was not done within seven (7) days after the completion of the annual MDS dated [DATE]. G. On 04/15/26 at 3:26 PM, during an interview with the SSW, confirmed the following: 1. The CNA and physician did not attend R #4's meeting. 2. They did not provide input on R #4's care. 3. R #4's care plan meeting was not done within seven days of completion of the MDS dated [DATE]. R #5 H. Record review of R #5's admission record, no date, revealed R #5 was admitted to the facility on [DATE]. I. Record review of R #5's progress notes revealed the following: 1. On 04/02/26 a care plan meeting was held for R #5. The provider and a CNA with responsibility for R #5's care did not attend the IDT care plan meeting. 2. Staff did not document that input was received from the provider or a CNA who provided care to R #5. R #11 J. Record review of R #11's admission Record, no date, revealed an admission date of 03/14/25. K. Record review of R #11's care plan meeting note dated 02/19/26 revealed the following: 1. The interdisciplinary team did not include the physician and the CNA in the meeting. 2. Staff did not document that they received input from the physician or the CNA who provided care to R #11. L. On 04/15/26 at 3:29 PM, during an interview with the SSW confirmed the following IDT members did not attend R #11's care plan meeting: 1. The MDS Nurse, 2. The physician, 3. The CNA. R #18 (continued on next page)		

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	M. Record review of R #18's admission record, no date, revealed R #18 was admitted to the facility on [DATE]. N. Record review of R #18's care plan meeting note, dated 01/18/26, revealed the following: 1. The interdisciplinary team did not include the physician and the CNA in the meeting. 2. Staff did not document that they received input from the physician or the CNA who provided care to R #18. R #28 O. Record review of R #28's admission Record, no date, revealed R #28 was admitted to the facility on [DATE]. P. Record review of R #28's admission MDS, dated [DATE], revealed the MDS was completed on 02/25/26. Q. Record review of R #28's progress notes, dated 03/10/26, revealed the following: 1. The IDT held a care plan meeting on 03/10/26 (not within seven (7) days of the completion of the admission MDS on 02/25/26). 2. The IDT members present were Dietary, an RN, the MDS Coordinator, and two social services workers. 3. Staff did not document that input was received from the provider or a CNA who provided care to R #28. R. On 04/21/26 at 1:37 PM, during an interview with the Registered Nurse Associate Manager and the MDS Coordinator, they confirmed the following: 1. The IDT care plan meeting held for R #28 was not within seven (7) days after the completion of his MDS that was completed on 02/25/26. 2. The provider and a CNA with responsibility for R #28's care did not attend the IDT care plan meeting on 03/10/26. 3. Staff did not document if input was received from the provider or a CNA with responsibility for R #28's care prior to R #28's IDT care plan meeting on 03/10/26. 4. Staff do not contact the provider for input prior to the IDT care plan meetings. R #29 S. Record review of R #29's admission record, no date, revealed R #29 was admitted to the facility on [DATE]. T. Record review of R #29's quarterly MDS, dated [DATE], revealed the MDS was completed on (continued on next page)		

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	02/25/26. U. Record review of R #29's progress notes, dated 03/05/26, revealed the following: 1. The IDT held a care plan meeting on 03/05/26 (this was not within seven (7) days of the completion of the quarterly MDS on 02/25/26). 2. Staff did not document the IDT members that attended the care plan meeting. R #92 V. Record review of R #92's admission record, no date, revealed R #92 was admitted to the facility on [DATE]. W. Record review of R #92's progress notes, dated 02/19/26, revealed the following: 1. The interdisciplinary team did not include the physician and the CNA in the meeting. 2. Staff did not document that they received input from the physician or the CNA who provided care to R #92. Revision R #1 X. Record review of R #1's admission Record, no date, revealed R #1 was admitted to the facility on [DATE]. Y. Record review of R #1's Significant Change MDS dated [DATE], revealed R #1's Activities Assessment preferences were coded as follows: 1. Staff documented code 1 (very important) for R #1 to: a. Listen to music he likes. b. Be around animals such as pets. c. Keep up with the news. d. Go outside and get fresh air when the weather is good. 2. Staff documented code 2 (somewhat important) for R #1 to do his favorite activities. Z. Record review of R #1's Progress Notes revealed the following: 1. Nutrition/dietary note dated 03/04/26: .Resident has experienced 6.5% significant weight loss over the past 30 days. (continued on next page)		

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. Nursing note-skin issues dated 03/19/26: New skin issue, stage 2 pressure ulcer injury (open wound caused by excessive and sustained pressure on a particular part of the body that extends into the bottom layers of the skin but does not extend to the subcutaneous fat, muscle or bone) to sacrum (region of the lower back located just above the tailbone). AA. Record review of R #1's Nursing Restorative Plan of Care dated December 2025 revealed R #1 was discharged from the Restorative Nursing Program (RNP; a structured set of nursing interventions that focus on maximizing an optimal level of functioning, enabling residents to regain/retain their independence following the debilitating effects of illness or injury) on 12/11/25. BB. Record Review of R #1's care plan dated 09/16/24 revealed the following: 1. Revision 09/29/25: R #1 participates in RNP, Physical Therapy (PT; the treatment of disease, injury, or physical conditions by methods such as massage, heat treatment, and exercise rather than by drugs or surgery), and dining. 2. Staff did not revise R #1's care plan for his recent (03/04/26) weight loss of 6.5 % over the past 30 days. 3. Staff did not revise the activities section of the care plan to reflect R #1's current activity preferences after his SCSA MDS was completed. 4. Staff did not revise R #1's care plan to include that he had an actual stage 2 pressure ulcer. CC. On 04/21/26 at 4:40 PM, during an interview, RN #1 and LPN #1, the following was confirmed: 1. R #1 was discharged from the RNP on 12/11/25 and R #1's care plan was not revised. 2. The dietician documented that R #1 had significant weight loss of 6.5% on 03/04/26 and the care plan was not revised. 3. R #1's care plan was not revised to include his current activity preferences as documented on the Significant Change MDS dated [DATE]. 4. R #1's care plan has not been revised to include that R #1 has a stage 2 pressure ulcer. R #2 DD. Record review of R #2's Significant change MDS dated [DATE], revealed R #2's Activities Assessment preferences were coded 1-4 (1 not very important and 4 not important at all) as follows: 1. Staff documented code 2 (somewhat important) for R #2 to be around animals such as pets. 2. Staff documented code 1 (very important) for R #2 participate in religious services. EE. Record review of R #2's care plan revision date 02/17/26 revealed staff did not include #2 personal preferences from the Significant change MDS for the following: 1. R #2 to be around animals. (continued on next page)		

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. R #2 to participate in religious services. FF. On 04/16/26 at 1:49 PM, during an interview with the Activities Director (AD) stated the activity assessments and care plans should be based on each resident. The activity assessment of the residents' personal preferences should set a foundational goal. They should be included in the care plan. The AD confirmed that R #2's care plan was not client centered with R #2's personal preferences. R #5 GG. On 04/14/26 at 10:54 AM, during an interview, R #5 stated the following: 1. That it is difficult for him to go to group activities. 2. He was not provided with one-on-one activities. 3. They did not have one-on-one activities. 4. He is in his bed a lot and that he gets bored. HH. Record review of R #5's progress note dated 04/16/26 revealed during a visit with the Chaplin, R #5 stated he was bored and lonely. II. Record review of R #5's care plan, dated 12/19/25, revealed the following: 1. R #5 does not participate in group activities because he refuses. 2. Staff did not document R #5's preferences for activities or his need for one-on-one activities JJ. On 04/20/26 at 11:35 AM, during an interview, the AD confirmed that there is no documentation of one-on-one activities for R #5. The AD confirmed that R #5's staff did not document R #5's preferences for activities. R #124 KK. On 04/14/26 at 9:54 AM, during an interview R #124 revealed he had wax build up in his ear. R #124 stated staff have been putting drops in his ear and that he had been to an audiologist, but they can't get his ear unplugged. LL. Record review of R #124's care plan revealed staff did not document R #124's wax build up and interventions.		

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure the consultant pharmacist's recommendations were reviewed and implemented by the physician and/or the physician provided documentation of a rationale (set of reasons or a logical basis for a course of action) for not following the consultant pharmacist's recommendation in a timely manner for 3 (R #6, R #11, R #78) of 5 (R #2, R #6, R #11, R #78, and R #124) residents reviewed for unnecessary medications. This deficient practice could likely result in residents being at a higher risk of adverse side effects and residents receiving medications that are no longer necessary. The findings are: R #6 A. Record review of R #6's admission Record, no date, revealed R #6 was admitted to the facility on [DATE]. B. Record review of R #6's physician's orders revealed the following: 1. An order dated 03/14/26, for gabapentin (anticonvulsant medication used to treat partial seizures in epilepsy and nerve pain) 100 mg twice a day. 2. An order dated 03/13/26, for risperidone (an atypical antipsychotic medication used to treat schizophrenia, bipolar disorder, and autism-related irritability) 0.5 mg once a day. 3. An order dated 03/14/26, for venlafaxine (a prescription serotonin-norepinephrine reuptake inhibitor (SNRI) used to treat major depressive disorder, generalized anxiety disorder, social anxiety disorder, and panic disorder) 75 mg once a day. 4. An order dated 03/14/26, for carvedilol (beta-blocker used to treat high blood pressure (hypertension) and heart failure) 12.5 mg twice a day. 5. An order dated 03/14/26, for losartan potassium-HCTZ 50-12.5 mg once a day. 6. An order dated 03/14/26, for melatonin 6 mg at bedtime. C. Record review of R #6's pharmacy review, dated 01/07/26, revealed the following: 1. R #6 had a recent fall. 2. The pharmacist documented that the following medications could contribute to falls: a. Gabapentin 100 mg twice a day. b. Risperidone 0.5 mg once a day. c. Venlafaxine 75 mg once a day. d. Carvedilol 12.5 mg twice a day. (continued on next page)		

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	e. Losartan potassium-hydrochlorothiazide (a combination medication used to treat high blood pressure (hypertension) and reduce stroke risk) 50-12.5 mg once a day. f. Melatonin (a hormone produced by the brain to regulate sleep cycles) 6 mg at bedtime. 3. The pharmacist recommended R #6's medications be reviewed for changes. 4. The provider selected disagree. Please offer clinical rationale below. 5. The provider did not document a clinical rationale for why R #6's medications should not be changed. D. Record review of R #6's medical record, no date, revealed the provider did not document a clinical rationale for why R #6's medications should not be changed. E. On 04/21/26 at 2:02 PM, during an interview, the Registered Nurse Associate Manager confirmed the following: 1. On 01/07/26, the pharmacist recommended the provider review R #6's medications after a fall. 2. The provider did not document a clinical rationale for why R #78's medications should not be changed. 3. He was unsure of the process for ensuring the provider documents a clinical rationale for why he didn't follow the pharmacist's recommendations. R #11 F. Record review of R #11's admission Record, no date, revealed the following: 1. R #11 was admitted to the facility on [DATE]. 2. R #11 had the following diagnoses: a. Major depressive disorder, recurrent, moderate (depressive episodes with periods of remission in between moderate severity indicates significant symptoms and functional impairment but not complete disruption of daily life). b. Unspecified psychosis not due to a substance or known physiological condition (is a psychiatric diagnosis used when a person exhibits psychotic symptoms). c. Post-traumatic stress disorder, unspecified (is intrusive thoughts, avoidance behaviors, negative changes in mood and cognition, hyperarousal, and emotional numbing). G. Record review of R #11's physician's orders, revealed the following: 1. An order dated 08/28/25 for bupropion (medication used to treat depression) oral tablet extended release 24 Hour give 300 mg by mouth one time a day related to major depressive disorder recurrent, moderate. (continued on next page)		

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. An order dated 10/25/25 for duloxetine (medication used to treat major depressive disorder and anxiety disorder) HCl oral capsule delayed release. Sprinkle 60 mg (Duloxetine HCl) Give 60 mg by mouth two times a day related to major depressive disorder, recurrent, severe with psychotic symptoms. 3. An order dated 08/08/25 for quetiapine fumarate (medication used to treat major depressive disorder by balancing brain chemicals linked to mood and behavior) oral tablet 100 mg 1 tablet by mouth at bedtime related to unspecified psychosis not due to a substance or known physiological condition major depressive disorder, recurrent, severe with psychotic symptoms. H. Record review of R #11's Medication Regimen Review, dated 03/30/26, revealed the following: 1. The pharmacist recommended a GDR for R #11's order for bupropion 300 mg xl one time a day. a. The provider selected disagree. Please offer clinical rationale below. b. The provider wrote stable he did not document a clinical rationale for why a GDR should not be completed for R #11's bupropion 300 mg. 2. The pharmacist recommended a GDR for R #11's order for quetiapine 100 mg 1 tablet at bedtime. a. The provider selected disagree. Please offer clinical rationale below. b. The provider wrote resident is very depressed and unspecified psychosis he did not document a clinical rationale for why a GDR should not be completed for R #11's quetiapine 100 mg. 3. The pharmacist recommended a GDR for R #11's order for duloxetine 60 mg two times a day. a. The provider selected disagree. Please offer clinical rationale below. b. The provider wrote stable he did not document a clinical rationale for why a GDR should not be completed for R #11's duloxetine 60 mg. I. Record review of R #11's medical record, no date, revealed: 1. The provider did not document a clinical rationale for why a GDR should not be completed for R #11's bupropion 300 mg after the pharmacist's recommendation on 03/30/26. 2. The provider did not document a clinical rationale for why a GDR should not be completed for R #11's quetiapine 100 mg after the pharmacist's recommendation on 03/30/26. 3. The provider did not document a clinical rationale for why a GDR should not be completed for R #11's duloxetine 60 mg after the pharmacist's recommendation on 03/30/26. J. On 04/21/26 at 1:10 PM, during an interview, with Registered Nurse Manager (RNM) stated the following: 1. The provider was expected to review all pharmacist recommendations and sign the pharmacist recommendation forms for R #11. (continued on next page)		

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. RNM confirmed the provider did not agree with the pharmacist's recommendation. The provider was expected to document a clear clinical rationale for why they did not want to follow the recommendation for R #11's medications duloxetine, bupropion, and quetiapine. R #78 K. Record review of R #78's admission Record, no date, revealed the following: 1. R #78 was admitted to the facility on [DATE]. 2. R #78 had the following diagnoses: a. PTSD. b. Vascular dementia, unspecified severity, with other behavioral disturbance (involves cognitive decline caused by brain vascular damage (e.g., strokes), marked by sudden, stepwise changes in personality, mood, and conduct). c. Anxiety disorder (mental health conditions characterized by excessive, uncontrollable, and persistent fear or worry that interferes with daily life, lasting at least six months). d. Sleep disorder (disturb normal sleep patterns, affecting sleep quality, timing, or duration and causing excessive daytime sleepiness or impairment). L. Record review of R #78's physician's orders revealed the following: 1. An order dated 05/20/25, for oxycodone 5 mg every 6 hours as needed for pain. 2. An order dated 09/17/25, for olanzapine (an atypical antipsychotic medication primarily used to treat schizophrenia and bipolar 1 disorder) 2.5 mg in the morning for unspecified dementia with other behavioral disturbance. 3. An order dated 09/17/25, for olanzapine 5 mg at bedtime for dementia with other behavioral disturbance. 4. An order dated 07/13/25, for trazadone (a serotonin antagonist and reuptake inhibitor ([NAME]) antidepressant primarily used off-label for insomnia due to its strong sedative properties) 50 mg at bedtime for sleep, related to sleep disorder. 5. An order dated 01/09/26, for amlodipine besylate 5 mg once a day for high blood pressure. M. Record review of R #78's pharmacy review, dated 01/06/26, revealed the following: 1. R #78 had a recent fall. 2. The pharmacist documented that the following medications could contribute to falls: a. Oxycodone 5 mg every 6 hours. (continued on next page)		

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	b. Olanzapine 2.5 mg in the morning. c. Trazadone 50 mg at bedtime. d. Olanzapine 5 mg at bedtime. e. Amlodipine 5 mg once a day. 3. The pharmacist recommended R #78's medications be reviewed for changes. 4. The provider selected disagree. Please offer clinical rationale below. 5. The provider did not document a clinical rationale for why R #78's medications should not be changed. N. Record review of R #78's Medication Regimen Review, dated 01/20/26, revealed the following: 1. The pharmacist recommended a GDR for R #78's order for trazadone 50 mg at bedtime. 2. The provider selected disagree. Please offer clinical rationale below. 3. The provider did not document a clinical rationale for why a GDR should not be completed for R #78's trazadone 50 mg. O. Record review of R #78's Medication Regimen Review, dated 03/30/26, revealed the following: 1. The pharmacist recommended a GDR for R #78's order for olanzapine 2.5 mg in the morning. 2. The provider selected disagree. Please offer clinical rationale below. 3. The provider did not document a clinical rationale for why a GDR should not be completed for R #78's olanzapine 2.5 mg. P. Record review of R #78's medical record, no date, revealed: 1. The provider did not document a clinical rationale for why R #78's medications should not be changed due to falls after the pharmacist's recommendation on 01/06/26. 2. The provider did not document a clinical rationale for why a GDR should not be completed for R #78's trazadone 50 mg after the pharmacist's recommendation on 01/20/26. 3. The provider did not document a clinical rationale for why a GDR should not be completed for R #78's olanzapine 2.5 mg after the pharmacist's recommendation on 03/30/26. Q. On 04/21/26 at 2:07 PM, during an interview, the Registered Nurse Associate Manager confirmed the following: 1. On 01/06/26, the pharmacist recommended the provider review R #78's medications after a fall. (continued on next page)		

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. The provider did not document a clinical rationale for why R #78's medications should not be changed. 3. On 01/20/26, the pharmacist recommended a GDR for R #78's trazadone 50 mg. 4. The provider did not document a clinical rationale for why a GDR should not be performed for R #78's trazadone 50 mg. 5. On 03/30/26, the pharmacist recommended a GDR for R #78's olanzapine 2.5 mg. 6. The provider did not document a clinical rationale for why a GDR should not be performed for R #78's olanzapine 2.5 mg. 7. He was unsure of the process for the frequency of performing GDR's.		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review the facility failed to store food under sanitary conditions for all 127 residents who eat food from the kitchen (residents were identified by the resident Matrix provided by the Administrator on 04/20/26), when they failed to label and date food items in the receiving kitchen refrigerator. If the facility fails to store food under safe and sanitary conditions then this could likely lead to foodborne illnesses (Foodborne illness can occur if you eat foods that are contaminated with harmful pathogens such as bacteria, viruses, and fungi) in residents. The findings are: A. On 04/13/26 at 2:30 PM, during an observation of the receiving kitchen refrigerator, the walk-in refrigerator had a large container of Pace Picante sauce dated 03/12/26 opened, and the expiration date was 03/31/26. A Large Sour Cream container had no date when it was opened. B. On 04/13/26 at 2:30 PM, during an interview the Dietary Supervisor (DS) #25 stated staff are to mark the food items when they opened. Staff should also throw out expired food items. C. Record review of the facilities Dry Storage Policy reviewed date 12/18/15 revealed that food is to be labeled and dated on all storage containers.		

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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 5 (R #7, R #9, R #10, R #58, and R #112) of 6 (R #7, R #9, R #10, R #58, R #112, and R #133) residents reviewed for accuracy of documentation, when staff failed to: 1. Ensure the Preadmission Screening and Resident Review (PASRR, a mandatory federal program requiring Medicaid-certified nursing facilities to screen all applicants for serious mental illness and intellectual/developmental disabilities) included all mental health diagnoses for R #7 and R #112. 2. Update R #9's diagnosis when the pressure wound (injuries to skin and underlying tissue caused by prolonged pressure, friction, or shear, typically occurring over bony prominences like the sacrum, heels, or hips) was documented by the doctor as a chronic stage (long-standing, severe pressure injury that has persisted for an extended period, often months or years, and involves full-thickness tissue loss with exposed bone, tendon, or muscle) four (4) pressure ulcer.3. Document attempts to apply lotion to R #58's dry feet.4. Document communication with provider regarding change in antibiotics from intravenous to oral route for R #133. These deficient practices have the potential to negatively impact the care staff provide to meet residents' needs due to inaccurate records. The findings are: PASRR R #7 A. Record review of R #7's admission Record, no date, revealed the following: 1. R #7 was admitted to the facility on [DATE]. 2. R #7 diagnoses include: a. Post-traumatic stress disorder (PTSD; mental health condition triggered by experiencing or witnessing a traumatic event, characterized by persistent distressing symptoms that interfere with daily life). b. Major depressive disorder (MDD; a serious mental health condition characterized by persistent feelings of sadness, loss of interest in activities, and various emotional and physical problems). c. Anxiety disorder (mental health condition characterized by excessive, uncontrollable worry about everyday issues, affecting daily functioning and quality of life). B. Record review of R #7's PASRR dated 06/10/25 revealed that staff did not document R #7's diagnoses of PTSD, MDD, and anxiety disorder. R #112 C. Record review of R #112's admission Record, no date, revealed the following: 1. R #112 was admitted to the facility on [DATE]. 2. R #112 diagnoses include: a. PTSD. (continued on next page)		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 325092	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/14/2026
NAME OF PROVIDER OR SUPPLIER New Mexico State Veterans Home		STREET ADDRESS, CITY, STATE, ZIP CODE 992 South Broadway Truth OR Consequences, NM 87901	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	b. Anxiety disorder. D. Record review of R #112's PASRR dated 07/22/25 revealed that staff did not document R #112's diagnoses of PTSD and anxiety disorder. E. On 04/21/26 at 3:21 PM, during an interview the admission coordinator confirmed the following: 1. R # 7's diagnoses included PTSD, MDD, and anxiety disorder and the diagnoses should be included on the PASRR. 2. R #112's diagnoses included PTSD and anxiety disorder, and they should be included on the PASRR. Diagnosis R #9 F. Record review of R #9's wound care consultation progress note dated 11/21/25 revealed the following: 1. Chief Complaint: Follow-up evaluation of chronic stage four (4) sacral (region of the lower back located just above the tailbone) pressure injury with known osteomyelitis (an infection or inflammation of the bone, usually caused by bacteria which can lead to bone damage if untreated). G. Record review of R #9's Face sheet, no date, did not include the diagnosis of chronic stage 4 pressure ulcer. H. On 04/21/26 at 4:43 PM, during an interview with the MDS Coordinator, she confirmed the following: 1. The wound care doctor did document that R #9 had a stage 4 pressure ulcer on the visit note for 11/21/25. 2. Staff did not update R #9's diagnosis list to include stage 4 pressure ulcer. R #58 I. Record review of R #58's admission Record, no date, revealed R #58 was admitted to the facility on [DATE]. J. On 04/14/26 at 10:17 AM, during an observation and interview with R #58, the following was revealed: 1. R #58's feet appeared dry and flakey. 2. R #58 stated he had a cream for his feet but was not sure when the last time was that staff used it on his feet. K. Record review of R #58's skin evaluation, dated 03/23/26, revealed staff documented, Skin very dry and scaley on both feet. (continued on next page)		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	L. Record review of R #58's skin evaluation, dated 04/06/26, revealed staff documented, Both feet and lower legs very dry and flakey. M. Record review of R #58's progress note, dated 04/07/26, revealed staff documented applying cream on R #58's legs. R #58 had his personal cream that was irritating his legs. Staff advised R #58 to discontinue using that cream. Also, staff advised R #58 to try a different cream that the facility had. N. On 04/20/26 at 10:49 AM, during an interview, RN #16 stated the following: 1. R #58's feet were very dry. 2. She offers to put lotion on R #58's feet at least once a week when she completes her skin assessment. 3. R #58 refuses to allow her to put lotion on him. 4. She doesn't document R #58's refusal to allow her to put lotion on him. O. On 04/20/26 at 11:04 AM, during an interview, CNA #16 stated the following: 1. R #58's feet were very dry. 2. She offers to put lotion on R #58's feet when she gets him up. 3. Resident always refuses to put lotion and states he doesn't like it. 4. She does not document R #58's refusal to put lotion on. P. On 04/21/26 at 2:28 PM, during an interview, the Registered Nurse Associate Manager confirmed the following: 1. Staff did not document attempts to apply lotion to R #58's feet, or that R #58 refused to allow staff to apply lotion. 2. Staff were expected to document when they offered to put lotion on residents and they refused. R #133 Q. Record review of R #133's admission Record, no date, revealed the following: 1. R #133 was admitted on [DATE]. 2. Diagnosis include urinary tract infection. R. Record review of R #133's Physician's orders revealed the following: 1. Order dated 04/11/26: Levofloxacin intravenous solution (an antibiotic given through the vein that is used to treat various bacterial infections in many different parts of the body) give 750 milligrams (continued on next page)		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	intravenously one time a day for sepsis (a life-threatening condition caused by the body's extreme and dysregulated response to an infection, leading to organ dysfunction and potentially death) for 10 days. 2. Order dated 04/11/26: Levofloxacin oral tablet give 750 milligrams by mouth one time a day for urinary tract infection for 10 days. S. Record review of R #133's Nursing Progress Notes dated 04/11/26 through 04/20/26 revealed that staff did not document any communication with the provider regarding changing R #133's levofloxacin from IV to oral route. T. Record review of R #133's medical record revealed no Provider Progress Notes dated 04/11/26 through 04/20/26. U. On 04/21/25 at 4:48 PM, during an interview with the RN #1 he confirmed that staff did not document anything regarding changing R #133's levofloxacin in R #133's medical record.		

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on observation and interview, the facility failed to ensure a resident was treated with respect and dignity for 1 (R #124) of 1 (R #124) residents randomly sampled, when the staff failed to interact and explain to R #124 why they were in House 2. This deficient practice could likely result in residents feeling embarrassed, angry, and that their feelings are unimportant to the facility staff. The findings are: A. On 04/14/26 at 9:38 AM, during an interview, R #124 stated that staff sitting in the common area did not care about the residents. R #124 stated that they were two guard dogs just sitting around in the house. R #124 stated they were only there when the surveyors were there. R #124 stated when he asked them what they were doing, they did not respond to him. B. On 04/14/26 at 11:23 AM, during an observation of House 2 during lunch, it was observed that there were two staff sitting at the dining table eating lunch. They were interacting with each other but not with the residents. C. On 04/14/26 at 11:26 AM, during an interview, the DM stated the two staff members were medical record staff. The DM stated medical record staff aren't usually at the house. D. On 04/14/26 at 11:29 AM, during an interview, Medical Record Staff (MRS) #1 stated that she was at the house because she was told to be there. When asked if she is usually assigned to House 2, she stated that she goes where she is told to go. E. On 04/14/26 at 3:21 PM, during an interview with the Administrator, she stated she has directed staff to start going to the different units to get to know the residents. The Administrator stated that her expectation is they be engaged with the residents and not just sitting around. The Administrator stated she would expect them to answer a resident if they were asked why they were at the unit.		

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. Based on record review and interview, the facility failed to ensure residents and/or their representatives were informed in advance of what medications they received and understood the reasons, risks, and benefits of the medications for 1 (R #2) of 5 (R #2, R #6, R #11, R #78, and R #124) residents reviewed for unnecessary medications. If the residents or their representatives are not informed of the risks and benefits of the medication or treatment alternatives, this deficient practice could likely result in residents and/or their representatives not being able to make informed decisions regarding residents' care. The findings are: A. Record review of R #2's physician's orders revealed the following: 1. An order dated 04/06/26 for Sertraline (a psychotropic medication used to treat major depressive disorder) oral tablet 50 mg, give 1 tablet by mouth one time a day for major depressive disorder. B. Record review of R #2's medical record revealed staff did not document consent for Sertraline. C. On 04/21/26 at 1:22 PM, during an interview House Supervisor (HS) #24 confirmed R #2 had an order for Sertraline to treat depressive disorder. The HS #24 stated that there should be consents completed for psychotropic medications. R #2 did not have a consent for Sertraline in his record.		

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to provide the required transfer information for 1 (R #1) of 2 (R #1 and R #128) residents reviewed for hospitalizations when staff failed send a copy of the written notice of transfer to the Ombudsman. This deficient practice could likely result in the residents and/or their representatives not receiving assistance from the ombudsman in the transition from the nursing home. 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. Record review of R #1's nursing progress note, dated 02/25/26, revealed R #1 was transferred to the hospital due to altered mental status (AMS; a broad term describing any change in a person's awareness, cognition, or behavior from their usual baseline, ranging from mild confusion to complete unresponsiveness). C. Record review of R #1's medical record, no date, revealed staff did document a written transfer notice and bed hold notice for R #1's transfer to the hospital on [DATE]. D. On 04/21/26 at 4:43 PM, during an interview, RN #1 stated that the nursing staff complete the transfer notice at the time of transfer but was unsure if the notice is sent to the ombudsman. E. On 04/22/26 at 1:58 PM, during an interview, the ombudsman stated that the facility does not send her a copy of the written transfer notices.		

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure a comprehensive MDS assessment was completed within 14 calendar days after admission for 1 (R #132) of 2 (R #28 and R #132) residents reviewed for MDS timing. This deficient practice could likely result in residents' needs not being met. The findings are: A. Record review of R #132's admission Record, no date, revealed R #132 was admitted to the facility on [DATE]. ^ B. Record review of R #132's MDS assessments revealed staff did not complete his admission MDS assessment until 04/13/26. ^ C. On 04/21/26 at 4:27 PM, during an interview, the MDS Coordinator confirmed staff did not complete R #132's admission MDS assessment within 14 days of admission to the facility.^		

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F 0638 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assure that each resident's assessment is updated at least once every 3 months. Based on record review and interview, the facility failed to ensure that an MDS assessment was completed every three months for 1 (R #10) of 1 (R #10) residents reviewed for MDS assessments when they failed to complete a quarterly MDS assessment within 92 days of the previous assessment reference date (ARD; the specific end point for the look-back periods in the MDS assessment process, also called the observation or assessment period.). This deficient practice could result in residents' assessments being outdated and residents not receiving care and treatment that meets their current needs. The findings are: A. Record review of R #10's Significant Change MDS assessment revealed an ARD of 12/08/25. B. Record review of R #10's Quarterly MDS assessments revealed an ARD of 03/23/26 (105 days after 12/08/25). C. On 04/21/26 at 4:36 PM, during an interview, the MDS Coordinator confirmed staff did not complete R #10's MDS assessments within 92 days of R #10's Significant Change MDS.		

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F 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Encode each resident's assessment data and transmit these data to the State within 7 days of assessment. Based on record review and interview, the facility failed to complete and transmit a MDS assessment within 14 days of completion (sign off by RN) for 1 (R #10) of 1 (R #10) residents reviewed for MDS assessments. This deficient practice could lead to the facility not reporting information in a timely manner (within 14 days) to the federal agency. The findings are: A. Record review of R #10's Quarterly MDS revealed a completion date of 03/31/26. B. Record review of R #10's Quarterly MDS revealed the facility transmitted the MDS to the federal agency on 04/15/26. C. On 04/21/26 at 4:36 PM, during an interview, the MDS Coordinator confirmed staff did not transmit R #10's Quarterly assessment to the federal agency within 14 days of completion.		

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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 meet professional standards of practice for 1 (R #132) of 4 (R #1, R #9, R #132, R #133) residents reviewed for medical care, when staff failed to implement an order after a doctor visit. This deficient practice could likely lead to unnecessary discomfort, prolonged symptoms or worsening of medical conditions. The findings are: A. Record review of R #132's admission Record, no date, revealed R #132 was admitted to the facility on [DATE]. B. On 04/14/26 at 9:51 AM, during an interview, R #132 stated the following: 1. He has a cough with a lot of phlegm that has had for several weeks. 2. He was seen by the facility doctor approximately two weeks ago where he told the doctor he had a cough with phlegm. 3. R #1 stated the doctor told him he would prescribe cough syrup for him. 4. R #1 has not received any cough syrup yet. B. Record review of R #132's provider visit note dated 04/01/26 revealed the following: 1. R #1 has a cough with phlegm. 2. Will prescribe Robitussin cough syrup. C. Record review of R #132's physician's orders revealed staff did not document any orders for cough syrup. D. Record review of R #132's Nursing Progress Notes revealed a note written by the ADON dated 04/01/26: [name of facility doctor] in to see resident. New orders noted. E. On 04/21/26 at 4:29 PM, during an interview, RN #1 stated the following: 1. The ADON is not at the facility today (04/21/26). 2. The ADON goes with the facility doctor when he sees residents, and she enters any new orders that the doctor wants to implement for residents. 3. R #132 does not have an order for cough syrup.		

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observation, and interview, the facility failed to provide an ongoing program of activities designed to meet the interests for 2 (R #2, and R #5) of 4 (R #1, R #2, R #5, and R #29) residents reviewed for activities by not providing meaningful individualized activities based upon residents' interests. If residents are not provided or encouraged to attend/participate in activities that meet their interests, then they are likely to experience an increase in boredom, isolation, and depression. The findings are: R #2 A. Record review of R #2's admission Record, no date, revealed R #2 was admitted to the facility on [DATE]. B. Record review of R #2's Significant change MDS dated [DATE], revealed R #2's Activities Assessment preferences were coded as follows: 1. Staff documented code 2 (somewhat important) for R #2 to be around animals such as pets. 2. Staff documented code 1 (very important) for R #2 participate in religious services. C. Record review of R #2's care plan revision date 02/17/26 revealed staff did not include #2 personal preferences for the following: 1. To be around animals. 2. To participate in religious services. D. Record review of R #2's Daily Participation Record, for February 2026, revealed staff did not document activities for R #2's personal preferences of being around animals or participating in religious services. E. Record review of R #2's Daily Participation Record, for March 2026, revealed staff did not document activities for R #2's personal preferences of being around animals or participating in religious services. F. On 04/16/26 at 1:49 PM, during an interview with the Activities Director (AD) stated the activity assessments and care plans should be based on each resident. The activity assessment of the residents' personal preferences should set a foundational goal and be included in the care plan. The AD confirmed that R #2's care plan was not client centered to include R #2's personal preferences. She stated that due to R #2's lack of participation R #2 should receive one-to-one activity in his activity program. R #5 G. Record review of R #5's admission record, no date, revealed R #5 was admitted to the facility on [DATE]. (continued on next page)		

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	H. On 04/14/26 at 10:54 AM, during an interview, R #5 stated the following: 1. It is difficult for him to go to group activities. 2. Staff do not provide one-on-one activities. 3. He is in his bed a lot and that he gets bored. I. Record review of R #5's progress notes, dated 04/16/26, revealed during a visit with the Chaplin, R #5 stated he was bored and lonely. J. Record review of R #5's Significant Change MDS assessment dated [DATE] revealed R #5's personal preferences for activities revealed the following: 1. It was very important to listen to music. 2. It was very important to go outside to get fresh air when the weather is good. K. Record review of R #5's care plan, dated 12/19/25, revealed R #5 did not participate in group activities because he refuses. R #5's care plan did not include his personal preferences from the Significant Change MDS. L. Record review of R #5's medical record, no date, revealed staff did not document one-on-one activities or activities that meet R #5's interest. M. On 04/20/26 at 11:35 AM, during an interview, the AD stated that staff converse with residents and watch movies with them for one-on-one activities. The AD stated that staff try to do activities in the different homes and in the annex for the residents that don't go to the main building for activities. The AD confirmed that she did not see that any one-on-one activities had been offered to R #5. The AD confirmed R #5's preferences are not documented in his medical record. The AD confirmed that she did not know if R #5 enjoyed watching movies or conversing as an activity.		

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F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 #87) of 4 (R #1, R #11, R #78, and R #87) resident reviewed for Activities of Daily Living (ADL) care when staff failed to provide nail care for R #87's toenails. This deficient practice could likely cause residents to have podiatric complications (foot and toenail health issues such as ingrown toenails, fungal infections, and trauma-related injuries). The findings are: A. Record review of R #87's admission Record, no date, revealed the following: 1. R #87 was admitted to the facility on [DATE]. 2. R #87 had the following diagnoses: a. Onycholysis (the painless separation of the nail plate from the nail bed, frequently starting at the tip or sides). b. Type 2 Diabetes Mellitus with Unspecified Complications. B. On 04/14/26 at 8:46 AM, during an observation and interview with R #87, the following was revealed: 1. R #87's toenails appeared long and discolored. 2. R #87 confirmed that his toenails were very long. 3. R #87 wanted them to be cut. 4. R #87 stated that his toenails needed to be cut by the podiatrist (a specialist focused on the medical and surgical care of the foot, ankle, and lower leg). 5. R #87 was unable to remember the last time his toenails had been cut. C. On 04/14/26 at 9:01 AM, during an interview, RN #16 confirmed the following: 1. R #87's toenails were long. 2. She was not sure how frequently the podiatrist visited the facility. 3. She was unsure of the last time R #87 had his toenails cut. D. Record review of R #87's progress notes revealed the following: 1. On 01/05/26, staff documented that R #87 was scheduled to see the podiatrist but was in the hospital. R #87 would be rescheduled. 2. On 09/25/25, staff documented R #87 was last seen by the podiatrist on 01/24/25 and a request would be made for R #87 to see the podiatrist. E. On 04/21/26 at 2:42 PM, during an interview, the Registered Nurse Associate Manager confirmed the following: 1. Only the podiatrist was able to cut toenails for residents with a diagnosis of Diabetes Mellitus or nail issues. 2. He was unable to determine when the last time R #87 was seen by the podiatrist.		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. Based on observation, record review, and interview, the facility failed to properly store medications for 2 (R #46 and R #85) of 2 (R #46 and R #85) residents randomly sampled for medication storage, when staff failed to ensure medications were not expired in treatment cabinet for R #46, and R #85. This deficient practice could likely result in residents obtaining medications not prescribed to residents, and that are no longer effective, resulting in adverse side effects. The findings are: A. On 04/15/26 at 2:14 PM, during an observation of house #1's Treatment Cabinet, revealed one medication of Diclofenac sodium Tropical gel, 1% expired on February 2026. B. On 04/15/26 at 2:14 PM, during an interview with LPN #28 confirmed the following: 1. Nurses are to check daily and make sure the medications are not expired. 2. Nurses are to follow facility process for expired medications. 3. LPN #28 stated she did not know who the Diclofenac sodium Tropical gel was prescribed to because there was no name on medication. 4. LPN #28 confirmed the medication Diclofenac sodium Tropical gel, 1% expired on February 2026. C. On 04/21/26 at 11:59 AM, during an interview with Administrator confirmed she expects the nurses to do weekly and daily cleaning of medication carts and treatment cabinets/carts for expired medications. D. On 04/22/26 at 1:04 PM, during an interview the ADON stated the following: 1. R #46 and R #85 had current orders for Diclofenac PRN. 2. She was not sure why the medication did not have a resident name on the box. 3. She did not know which resident it belonged to. 4. ADON's expectation is that staff take expired medications to the medication room to be sent for destruction by the pharmacist.		

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NAME OF PROVIDER OR SUPPLIER New Mexico State Veterans Home		STREET ADDRESS, CITY, STATE, ZIP CODE 992 South Broadway Truth OR Consequences, NM 87901	
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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 infection prevention and control program for 1 (R #107) of 2 (R #9 and R #107) residents reviewed for Transmission Based Precautions (additional infection control measures used in healthcare settings alongside Standard Precautions. They prevent the spread of known or suspected pathogens) when staff failed to follow enhanced barrier precautions (EBP, an infection control intervention) for R #107. If the facility fails to maintain an effective infection control program, then infections could spread to residents throughout the facility, resulting in illness. The findings are: A. Record Review of the [Name of Federal Agency] Enhanced Barrier Precautions in Nursing Homes to Prevent Spread of Multidrug-resistant Organisms (MDROs), dated 03/20/24, revealed the following: 1. MDRO transmission is common in long term care (LTC) facilities. 2. EBP refers to an infection control intervention designed to reduce transmission of MDRO that employs targeted gown and glove use during high contact resident care activities. a. Examples of high-contact care activities include: i. Dressing ii. Bathing/showering iii. Transferring iv. Changing linens v. Providing hygiene vi. Changing briefs or assisting with toileting vii. Device care or use: Central line, urinary catheter, feeding tube, or tracheostomy viii. Wound Care: any skin opening requiring a dressing 3. EBP are indicated for residents with wounds or indwelling medical devices, even if the resident is not known to be infected or colonized with a MDRO. B. Record review of R #107's admission Record, no date, revealed R #107 was admitted to the facility on [DATE]. C. Record review of R #107's physician's orders revealed the following; 1. An order dated 02/27/26, for EBP related to foley catheter. D. On 04/14/26 at 9:21 AM, during an observation and interview with R #107, the following was revealed:1. There was an EBP sign visible on the bathroom door when entering R #107's room.2. R #107 had a foley catheter bag hanging on his bed frame.3. Gloves were hanging on the wall next to the door.4. There were no gowns visible when in R #107's room.5. R #107 stated staff do not wear gowns when transferring him to his wheelchair or showering him. E. On 04/14/26 at 9:25 AM, during an interview, CNA #17 stated the following:1. There should be a box with gowns and gloves in the resident's room if they are on EBP.2. She was unsure if R #107 was on EBP. F. On 04/14/26 at 9:27 AM, during an interview, LPN #16 stated the following:1. She confirmed R #107 was on EBP due to having a foley catheter.2. Staff were expected to wear gowns and gloves when working with R #107's foley catheter.3. Staff did not need to wear gowns when transferring residents who were on EBP, only when touching their wound or catheter.4. She stated that gowns were available in the nurse's station.5. After searching through all of R #107's drawers, she located gowns in R #107's top dresser drawer.6. After looking at the EBP sign, she confirmed the EBP sign indicated staff were supposed to wear gowns for high contact resident care.7. She confirmed that the EBP sign indicated that high contact resident care included dressing, transferring, and showering residents. G. On 04/21/26 at 2:52 PM, during an interview, the Registered Nurse Associate Manager confirmed the following: 1. There should be an EBP sign and a bin with PPE near the entrance of residents' rooms who were on EBP. 2. Staff were expected to wear gowns and gloves when they had direct contact with residents' wounds or catheters (contradicts finding A)		

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure residents were educated on and offered the influenza (Flu: highly contagious respiratory illness caused by the influenza viruses that infection the nose, throat and sometimes the lungs leading to mild and potentially severe illness) and pneumococcal (moderate to highly contagious respiratory illness caused by bacteria that infect the nose throat and sometimes the lungs and can lead to severe illness such as pneumonia) immunizations and ensure that residents who completed and signed a consent form received the vaccination for 2 (R #112, R #132) of 5 (R #2, R #28, R #112, R #124, and R #132) residents reviewed for immunizations. If residents are not vaccinated appropriately for influenza and pneumococcus then they have a higher likelihood of contracting the illness and spreading the infection to other residents in the facility. The findings are: R #112A. Record review of R #112's admission Record, no date, revealed R #112 was admitted to the facility on [DATE]. B. Record review of R #112's medical record revealed the following: 1. R #112 signed an immunization consent form on 07/22/25 accepting the influenza vaccine annually. 2. Record review of R #112's Immunization report dated 01/01/15 through 04/30/26 revealed R #112 received his last influenza vaccine on 10/15/22. R #132C. Record review of R #132's admission Record, no date, revealed R #132 was admitted to the facility on [DATE]. D. Record review of R #132's medical record, no date revealed the following: 1. R #132 did not have any immunization consent form on file. 2. Staff did not document regarding R #132 being offered the influenza or pneumococcal vaccines. E. On 04/21/25 at 3:39 PM, during an interview with the RN #1 he confirmed the following: R #112 completed a consent for but did not receive the influenza vaccine for the 2025-2026 (October 2025 through May 2026) flu season. R #132's medical record did not contain information regarding R #132's influenza and pneumococcal vaccines. Staff did not document that R #132 was educated and offered the influenza and pneumococcal vaccines.		

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. Based on record review and interview, the facility failed to offer COVID-19 (an acute respiratory disease in humans characterized mainly by fever and cough, capable of progressing to severe symptoms and in some cases death) vaccinations to 2 (R #2 and R #132) of 5 (R #2, R #28, R #112, R #124, and R #132) residents reviewed for COVID-19 vaccinations. This deficient practice could likely result in residents having a higher likelihood of contracting COVID-19 and spreading the infection to other residents in the facility. The findings are: R #2A. Record review of R #2's Immunization Report revealed the last COVID-19 vaccination that R #2 received was on 01/20/22. B. Record review of R #2's medical record revealed the record did not contain any COVID-19 vaccine forms which indicated staff offered or administered the COVID-19 vaccine to the resident. R #132C. Record review of R #132's medical record revealed the following: 1. R #132 did not have any immunization consent forms on file. 2. Staff did not document regarding R #132 being offered COVID-19 vaccine. D. On 04/21/26 at 3:39 PM, during an interview with RN #1 he confirmed the following: R #2's medical record did not contain any evidence that R #2 was offered the COVID-19 vaccine. R #132's medical record did not contain any evidence that R #132 was offered the COVID-19 vaccine. E. Record review of the Center for Disease Control and Prevention's website, https://www.cdc.gov/covid/vaccines/long-term-care-residents.html, stated the following: 1. CDC recommends an updated (2025-2026) COVID-19 vaccine for most adults ages 18 years and older. 2. CDC recommends everyone ages 65 years and older, including people who live and work in LTC settings, get 2 doses of an updated COVID-19 vaccine 6 months apart.		

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F 0577 Level of Harm - Potential for minimal harm Residents Affected - Many	Allow residents to easily view the nursing home's survey results and communicate with advocate agencies. Based on interview and observation, the facility failed to post the most recent state survey results in areas of the facility that were in a prominent and accessible location for residents and the public. This could affect all 128 residents in the facility (residents were identified by the Census Report provided by the Administrator on 04/13/26). If residents are unable to locate the latest survey conducted by the State Surveyors, then residents, representatives, and visitors are likely unable to know how the facility is doing and make decisions accordingly. The findings are: A. On 04/16/26 at 11:01 AM, during an interview at the Resident Council meeting, R #30, R #64, R #90, R #82, and R #100 revealed they did not know where the latest state survey results were located. B. On 04/16/26 at 11:45 AM, an observation revealed a binder with the survey results was located in the front hall of the main building [the portion of the campus where offices are located but residents do not reside]. C. On 04/21/26 at 4:23 PM, during an interview, the Administrator confirmed the survey results were only located in the main building. The Administrator confirmed that not all the residents go to the main building. The Administrator confirmed that the survey results would not be accessible to all residents or the public.		

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. Based on observation and interview, the facility failed to publicly post nurse staffing data on a daily basis, this has the potential to affect all 128 residents (residents were identified by the census list provided by the Medical Records Director on 04/13/26), when staff failed to post required staffing information. This deficient practice could likely prevent residents and the public from having access to accurate current and previous staffing records. The findings are: A. On 04/21/26 at 9:18 AM, during an observation of the lobby area of the annex, the following was revealed: 1. The Daily Per Patient Day (PPD, a key metric in nursing homes and healthcare, representing the total hours of care provided to a patient divided by the total number of patients daily) form was displayed on the counter. 2. The Daily PPD form was dated 04/13/26 to 04/19/26. 3. The form included the number of nursing hours and CNA hours per shift. 4. The form did not include the number of staff working. 5. The form did not include the staffing information for the current date (04/21/26). B. On 04/21/26 at 9:27 AM, during an interview, the Senior Manager of Administration stated the following: 1. The Daily PPD form that was posted did not include the current date of 04/21/26. 2. The information on the Daily PPD form was predicted staffing hours and not actual hours worked. 3. The Daily PPD form was supposed to be posted weekly on Monday mornings. C. On 04/21/26 at 9:33 AM, during an interview, the Nursing Administration Administrative Assistant confirmed the following: 1. The Daily PPD form was supposed to be posted weekly on Monday mornings. 2. The Daily PPD form that was posted did not include the current date of 04/21/26. 3. The Daily PPD form had the predicted staff hours for the upcoming shifts. 4. The Daily PPD form indicated the number of hours scheduled, it did not indicate the number of staff members working each shift. 5. Staff did not update and repost the Daily PPD form with actual hours worked each shift or changes to the census. 6. If a resident or member of the public reviewed the form, they would not be able to determine how many staff were currently working at that time. D. On 04/21/26 at 1:21 PM, during an interview, the Administrator confirmed the following: 1. Staff were expected to post the Daily PPD form daily, not weekly. 2. Staff were expected to document actual staffing numbers on the Daily PPD form, not the predicted staffing hours.		