STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	325116	A. Building B. Wing	12/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mescalero Care Center	454 Lipan Avenue Mescalero, NM 88340

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0568 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Properly hold, secure, and manage each resident's personal money which is deposited with the nursing home. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0568 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** R #24A. Record review of R #24's admission documents, no date, revealed R #24 was admitted to the facility on [DATE]. B. Record review of an incident report for R #24 submitted to the state agency, dated 10/10/25, revealed the following: 1. Incident date 09/17/25.2. On 09/17/25, R #24 reported that Business Office Manager (BOM) #1 never let him know how much money he had in his account. C. Record review of R #24's personal fund transaction history, dated 01/01/25 to 11/30/25, revealed the following: 1. R #24's balance on 07/24/25 was $7,208.42.2. The last transaction documented in R #24's account was dated 07/24/25. 3. R #24 received monthly deposits for the same amount. 4. Staff did not document any deposits or withdrawals from R #24's account after 07/24/25. D. Record review of R #24's quarterly financial statement, dated 09/30/25, revealed the amount in R #24's account was $7,208.42 (the same as the amount listed on the financial history report that ended on 07/24/25). R #25E. Record review of R #25's personal fund transaction history, dated 01/01/25 to 12/05/25, revealed the following:1. R #25's balance on 07/28/25 was $299.38. 2. The last transaction documented in R #25's account was dated 07/28/25. 3. R #25 received monthly deposits each month. 4. R #25 had withdrawals for shopping and for salon services multiple times each month. 5. Staff did not document any deposits or withdrawals from R #25's account after 07/28/25. F. Record review of R #25's quarterly financial statement, dated 09/30/25, revealed the amount in R #25's account was $299.38 (the same as the amount listed on the financial history report that ended on 07/28/25). R #26G. Record review of R #26's personal fund transaction history, dated 01/01/25 to 12/05/25, revealed the following:1. R #26's balance on 07/24/25 was $476.02. 2. The last transaction documented in R #26's account was dated 07/24/25. 3. R #26 received monthly deposits each month. 4. R #26 had withdrawals for shopping and for salon services multiple times each month. 5. Staff did not document any deposits or withdrawals from R #26's account after 07/24/25. H. Record review of R #26's quarterly financial statement, dated 09/30/25, revealed the amount in R #26's account was $476.02 (the same as the amount listed on the financial history report that ended on 07/24/25). I. On 12/4/25 at 8:18 AM during an interview with R #26, she stated BOM #1 was doing something with her money. BOM #1 made R #26 feel uncomfortable and R #26 doesn't trust her. BOM #1 would not want to give R #26 when she asked for statements (she was not sure of the dates she had requested the statements). R #28J. Record review of R #28's personal fund transaction history, dated 01/01/25 to 12/05/25, revealed the following:1. R #28's balance on 07/28/25 was $1,981.24. 2. The last transaction documented in R #28's account was dated 07/28/25. 3. R #28 received monthly deposits each month. 4. R #28 had withdrawals for shopping and for salon services multiple times each month. 5. Staff did not document any deposits or withdrawals from R #28's account after 07/28/25. K. Record review of R #28's quarterly financial statement, dated 09/30/25, revealed the amount in R #28's account was $1,981.24 (the same as the amount listed on the financial history report that ended on 07/28/25). L. On 12/05/25 at 10:48 AM, during an interview, BOM #2 stated the following:1. The BOM deposits resident funds into the bank. 2. She stated the bank does not give the facility statements regarding the resident financial accounts that are through the facility. 3. She was not able to determine how much money each resident actually had in their account. 4. The facility tries to keep a record of each resident's account, but since she cannot look at the bank statements, she is unable to determine how much money each resident actually have.5. Each resident's financial account should be manually updated by the BOM with deposits and withdrawals.6. She confirmed that R #24, R #25, R #26, and R #28 accounts had not been updated with deposits and withdrawals since July 2025.7. The statements residents were given on 09/30/25 were not accurate because they did not include any transactions that occurred after the last date listed in the transaction history for each resident.8. She was not sure if residents or their representatives were provided with quarterly statements prior to 09/30/25.9. She confirmed the BOM was expected to provide residents with accurate financial statements at least quarterly and if requested by the resident or representative.10. She became the BOM in September 2025.11. She stated that multiple residents had reported that the previous BOM did not provide them with financial statements and had stated they didn't know how much money they had.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to protect residents from abuse, neglect, and exploitation for 3 (Anonymous R #1, Anonymous R #2, and R #24) of 5 (Anonymous R #1 and Anonymous R #2, R #24, R #25, R #26) residents sampled for abuse, neglect, and exploitation for the following:1. The Business Office Manager (BOM) #1 attempted to exploit R #24's resident funds in the amount of $7208.42. 2. BOM #1 was witnessed on two separate occurrences in the front lobby and in resident common area yelling at other staff members. 3. Anonymous R #1, Anonymous R #2 are fearful of retaliation (getting kicked out of the facility) for speaking out against BOM #1 who is directly related to the tribal leadership. These deficient practices could result in facility not maintaining a safe environment for residents' psychosocial wellbeing, residents could experience feeling powerless, violated, fearful, and unsure of how to regain control over their lives and continue to trust staff and feel safe in their home. The findings are: R #24 A. Record review of R #24's administration record, no date revealed R #24's admission date of 01/15/25. B. Record review of R #24's quarterly MDS dated [DATE], revealed the following BIMS score of 15. C. Record review of R #24's initial incident report submitted to the state agency, dated 10/10/25, revealed the following: 1. Incident date 09/17/25 2. On 09/17/25, R #24's Power of Attorney (POA, the authority to act for another person in specified or all legal or financial matters) attempted to withdrawal R #24's money from his facility account (see finding D). D. Record review of R #24's follow-up report submitted to the state agency, dated 10/13/25, revealed the following 1. R #24's POA (who was also BOM #1) was an employee of the facility at the time she tried to take R #24's money from his facility account. 2. The amount of money R #24's POA tried to remove was $7208.42 from his account. The facility prevented her from doing so. E. On 12/04/25 at 2:03 PM, during an interview, the Administrator confirmed the following: 1. R #24's POA was the BOM #1 for the facility. 2. The incident with R #24's POA occurred on 09/17/25. 3. R #24 was informed that the BOM #1 was attempting to take his money and he did not want BOM #1 to take his money. 4. R #24 BIMS score was 15 and was able to make financial decisions.5. Staff did not allow the BOM #1 to take R #24's $7208.42. BOM #1 yelling at staff in front of residentsF. Record review of Anonymous R #1quarterly MDS dated [DATE], revealed the following BIMS score of 13. G. On 12/04/25 at 1:30 PM, during an interview, Anonymous R #1 stated she witnessed BOM #1 yelling at other staff members in the front lobby area coming out of her office. She stated that there were other residents sitting in wheelchairs in the lobby area (Anonymous R #1 couldn't recall the specific date or specific residents). H. Record review of Anonymous R #2 quarterly MDS dated [DATE], revealed the following BIMS score of 15. I. On 12/04/25 at 7:30 AM, during an interview, Anonymous R #2 stated BOM #1 yelled at staff members in the hallway in common resident area by nurse's station. Anonymous R #2 stated there were several other residents who were in the area with him (Anonymous R #2 couldn't recall the specific date or specific residents). J. On 12/3/25 at 1:22 PM during a dual interview with the Administrator and BOM #2 confirmed the following:1. The BOM #1 had a history of yelling at staff. Some of those incidents happened in front of residents. The Administrator gave the following examples: a. BOM #1 was yelling at BOM #2 and the Administrator when she was attempting to get R #24's funds of $7208.42. BOM #1 entered the Administrator's personal space in an aggressive manner. b. BOM #1 was heard yelling in front lobby area by the Administrator and other residents (the Administrator could not recall what residents) when he entered the BOM office two family members (two women related to R #26), huddled together and Social Services worker (SSW) was sitting in the corner, and all appeared scared. It was reported to the State Agency. BOM #1's employment was terminated by the facility. That decision is in appeal with K. On 12/05/25 at 10:06 AM, during an interview, the Ombudsman stated BOM #1 walked intentionally into her shoulder in an effort to intimidate her in the front lobby area (approximately June or July 2025). BOM #1 stated to the ombudsman light weight. Ombudsman stated she was afraid of BOM #1 and had not been to the facility since the incident. Fearful of RetaliationL. On 12/04/25 at 1:30 PM, during an interview with Anonymous R #1 revealed the following:1. Anonymous R #1 stated she's afraid of BOM #1 because she knows a lot of very important people in the [NAME]. Anonymous R #1 thinks BOM #1 would do something to get her kicked out of the nursing home. Anonymous R #1 doesn't want to go anywhere because this is her home.2. Anonymous R #1 stated she does not want BOM #1 back. Anonymous R #1 stated BOM #1 is not a good person for this facility. Anonymous R #1 stated BOM #1 is a horrible person and shouldn't be working with elderly people. 3. Anonymous R #1 did not report this to anyone for fear of retaliation. M. On 12/04/25 at 7:30 AM, during an

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to report allegations of misappropriation of resident property (the deliberate misplacement, exploitation, or wrongful, temporary, or permanent use of a resident's belongings or money without the resident's consent) to the State Agency within 24 hours of the allegation for 1 (R #24) of 5 (R #24, R #25, R #26, R #27, and R #28) residents reviewed for misappropriation of property. If the facility fails to report allegations of misappropriation of property to the state agency within 24 hours of the allegation, then corrective action may not be taken, and residents may suffer increased anxiety and fear that their belongings are not being protected. The findings are: A. Record review of R #24 admission documents, no date, revealed R #24 was admitted to the facility on [DATE]. B. Record review of the initial incident report submitted to the state agency, dated 10/10/25, revealed the following: 1. Incident date 09/17/25 (incident submitted on 10/10/25, not within 24 hours of incident on 09/17/25). 2. On 09/17/25, R #24's Power of Attorney (POA, the authority to act for another person in specified or all legal or financial matters) attempted to withdrawal R #24's money from his facility account. C. Record review of the follow-up report submitted to the state agency, dated 10/13/25, revealed the following 1. R #24's POA was an employee of the facility at the time she tried to take R # 24's money from his facility account. 2. The amount of money R #24's POA attempted to remove from R #24's resident account was $7208.42. D. On 12/04/25 at 2:03 PM, during an interview, the administrator confirmed the following: 1. R #24's POA was the Business Office Manager (BOM) for the facility. 2. The incident with R #24's POA occurred on 09/17/25. 3. The facility did not report the allegations of misappropriation of R #24's money to the state agency until 10/10/25, which was not within 24 hours of the incident on 09/17/25.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. Based on observation and interview, the facility failed to meet professional standards of practice for medication administration for 5 (R #16, R #17, R #18, R #19, and R #25) of 8 (R #16, R #17, R #18, R #19, R #21, R #22, R #23, and R #25) residents reviewed for medication administration when staff failed to ensure medications were prepared immediately before medication administration for each resident.This deficient practice could likely lead to the residents receiving the incorrect medications and could cause adverse effects (an undesired harmful effect resulting from a medication or other intervention). The findings are: A. On 12/04/24 at 7:27 AM, during an observation of medication administration revealed the following: 1. LPN #16's medication cart had five (5) medicine cups with pills in them.2. Four (4) of the medication cups had initials on them.3. One of the medication cups with initials had one (1) pill in it.4. One of the medication cups with initials had five (5) pills in it.5. One of the medication cups with initials had two (2) pills in it6. One of the medication cups with initials had eight (8) pills in it.7. One (1) of the medication cups did not have initials on it and had ten (10) pills in it. B. On 12/04/24 at 7:30 AM, during an interview, LPN #16 revealed the following: 1. She prepared the residents' medications early to try to administer them to the residents quickly. 2. She stated she had written the resident's initials on the sides of the cups so she would know who they were for. 3. She stated the medication cup with one (1) pill was for R #16. 4. She stated the medication cup with five (5) pills was for R #17. 5. She stated the medication cup with two (2) pills was for R #18. 6. She stated the medication cup with eight (8) pills was for R #25. 7. She confirmed one of the medication cups had no initials on it. 8. She stated the medication cup with no initials and ten (10) pills was for R #19. 9. She stated that staff were not supposed to pre-pour (a type of workaround, described as a delay between preparation and administration of a medication or the preparation of multiple medications for different clients) medications for residents. C. On 12/04/24 at 7:47 AM, during a joint interview, the DON and ADON confirmed the following:1. Staff were not allowed to pre-pour medications for residents.2. Staff were expected to prepare each resident's medication and administer the medication to the residents immediately after preparation.3. Pre-pouring medications could likely result in staff administering medications to the incorrect residents and could lead to medication errors.