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	05/19/2025

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

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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 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. 41755 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 2 (R #119 and R #130) of 7 (R #1, R #9, R #10, R #11, R #118, R #119, and R #130) 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, they are not able to make informed decisions regarding residents' care. The findings are: R #119 A. Record review of R #119's physician's orders revealed an order dated 04/29/25 for trazadone (antidepressant medication) 25 mg as needed for sleep related to systolic (congestive) heart failure (occurs when the heart's left ventricle cannot contract effectively, leading to insufficient blood being pumped to the body). B. Record review of R #119's medical record revealed staff did not document consent for trazadone. C. On 05/19/25 at 2:12 PM, during an interview, the Director of Nursing (DON) confirmed that staff did not obtain the consent form for the trazadone for R #119. The DON confirmed that staff are expected to complete the psychotropic medication consent form prior to the resident starting psychotropic medications. R #130 D. Record review of R #130's physician's orders revealed the following: 1. 04/19/25 An order for hydroxyzine tablet (prescription-only antihistamine [medication with sedating and calming effect] that is used to treat anxiety) 25 mg, give one tablet by mouth two times daily related to anxiety. 2. 05/13/25 An order for trazodone tablet (antidepressant medication that is sometimes prescribed as a sleep aid) 50 mg, give one tablet by mouth in the evening for insomnia (common sleep disorder that makes it hard to fall asleep or stay asleep). E. Record review of R #130's medical record revealed staff did not document consent for hydroxyzine or trazodone. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	F. On 05/19/25 at 3:06 PM, during an interview, DON confirmed that staff did not obtain the consent form for hydroxyzine and trazodone for R #130. The DON confirmed that staff are expected to complete the psychotropic medication consent form prior to the resident starting psychotropic medications. The DON stated that the nurse should initially obtain verbal consent prior to administration of the first dose of the medications and then follow up with the written consent that is signed by the power of attorney (POA; legal document that appoints someone as a representative and allows them to act on one's behalf). 49313

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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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41755 Based on record review and interview, the facility failed to notify the provider of abnormal vital signs (blood pressure and heart rate outside of set parameters) for 1 (R #1) of 7 (R #1, R #9, R #10, R #11, R #118, R #119, and R #130) residents reviewed for unnecessary medications, when staff failed to notify the provider that R #1's blood pressure was high and R #1's pulse was low. This deficient practice could likely result in residents not receiving necessary care or worsening medical conditions due to lack of or changes in treatment. The findings are: A. Record review of R #1's admission record (no date) revealed the following: 1. R #1 was admitted to the facility on [DATE]. 2. R #1 had a diagnosis of essential (primary) hypertension (common form of high blood pressure that does not have a known secondary cause and is influenced by various lifestyle and genetic factors). B. Record review of R #1's physician orders revealed the following: 1. Amlodipine (high blood pressure primarily used to treat high blood pressure and chest pain by relaxing blood vessels which lowers blood pressure and decreases the hears workload) tablet 10 mg, give 1 tablet by mouth in the morning for high blood pressure (HTN; hypertension medical term for high blood pressure) hold (do not give medication) and call doctor if systolic blood pressure (SBP, top number of blood pressure reading) is less than 100, diastolic blood pressure (DBP, bottom number of blood pressure reading) is less than 50 and/or pulse (heart rate, beats per minute) is less than 50. Administer (give medication) and call doctor if SBP is greater than 180, DBP is greater than 100 and/or Pulse is greater than 100. C. Record review of R #1's Medication Administration Record (MAR; a form used to document medication administration), dated April 2025, revealed staff documented the following: 1. On 04/01/25 staff documented bp 195/63 and administered amlodipine. 2. On 04/05/25 staff documented bp 181/64 and administered amlodipine. 3. On 04/08/25 staff documented pulse 47 and administered amlodipine. 4. On 04/08/25 staff documented pulse 43 and administered amlodipine. 5. On 04/09/25 staff documented bp 184/81 and administered amlodipine. 6. On 04/12/25 staff documented bp 189/78 and administered amlodipine. D. Record review of R #1's MAR dated May 2025, revealed staff documented the following: (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1. On 05/04/25 staff documented bp 190/82 and administered amlodipine. 2. On 05/05/25 staff documented bp 198/74 and administered amlodipine. 3. On 05/06/25 staff documented bp 189/73 and administered amlodipine. 4. On 05/07/25 staff documented bp 185/76 and administered amlodipine. 5. On 05/10/25 staff documented bp 185/79 and administered amlodipine. 6. On 05/11/25 staff documented bp 217/92 and administered amlodipine. 7. On 05/13/25 staff documented bp 185/79 and administered amlodipine. 8. On 05/14/25 staff documented bp 182/70 and administered amlodipine. 9. On 05/15/25 staff documented bp 215/74 and administered amlodipine. E. Record review of R #1's progress notes for March and April 2025, revealed staff did not notify the physician of R #1's elevated blood pressure (SBP higher than 180) or low pulse (heart rate less than 50). F. On 05/19/25 at 3:19 PM, during an interview, the DON confirmed the following: 1. R #1's blood pressure was elevated, and her pulse was low. 2. R #1's order indicated that staff are to call physician when blood pressure is greater than 180 and heart rate is less than 50. 3. Facility staff did not call the physician as indicated.

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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 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** 41755 Based on record review, observation, and interview, the facility failed to ensure residents did not receive psychotropic medications (group of drugs that affect behavior, mood, thoughts, or perception. They are used to treat a variety of conditions including anxiety, depression, bipolar disorder, and schizophrenia) unless the medication was medically necessary for 6 (R #9, R #10, R #11, R #118, R #119, and R #130) of 7 (R #1, R #9, R #10, R #11, R #118, R #119, and R #130) residents reviewed for unnecessary medications, when staff failed to: 1. Psychotropic medications for R #118 and R #119 were prescribed to treat a specific psychiatric diagnosis (mental illness, symptoms or condition that greatly disturbs your thinking, moods, and/or behavior). 2. Psychotropic medications that were ordered to be given as needed (PRN) for R #119 were not prescribed for longer than 14 days without a rationale from the provider for why the medication was needed for longer than 14 days. 3. Carry out 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). 4. R #130 received psychotropic medications causing excessive sedation (state of calm or sleep induced by the administration of medication). 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, harmful, or abnormal result). The findings are: Diagnosis and PRN Orders R #118 A. Record review of R #118's admission record, no date, revealed R #118 was admitted to the facility on [DATE]. B. Record review of R #118's physician's orders revealed an order dated 04/03/25 for hydroxyzine (medication that can be used to treat anxiety) 25 mg at bedtime for restlessness or anxiety. C. Record review of R #118's MAR, dated 05/01/25 through 05/12/25, revealed the following: 1. On 05/01/25, R #118 received hydroxyzine 25 mg in the evening. 2. On 05/02/25, R #118 received hydroxyzine 25 mg in the evening. 3. On 05/03/25, R #118 refused hydroxyzine 25 in the evening. (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4. On 05/04/25, R #118 refused hydroxyzine 25 mg in the evening. 5. On 05/05/25, R #118 received hydroxyzine 25 mg in the evening. 6. On 05/06/25, R #118 received hydroxyzine 25 mg in the evening. 7. On 05/07/25, R #118 received hydroxyzine 25 mg in the evening. 8. On 05/08/25, R #118 received hydroxyzine 25 mg in the evening. 9. On 05/09/25, R #118 received hydroxyzine 25 mg in the evening. 10. On 05/10/25, R #118 received hydroxyzine 25 mg in the evening. 11. On 05/11/25, R #118 received hydroxyzine 25 mg in the evening. 12. On 05/12/25, R #118 refused hydroxyzine 25 mg in the evening. D. Record review of R #118's entire medical record, no date, revealed R #118 did not have a diagnosis of anxiety. E. On 05/19/25 at 2:16 PM, during an interview, the DON confirmed the following: 1. R #118 had an order for hydroxyzine for restlessness or anxiety. 2. R #118 did not have a diagnosis of anxiety. 3. Staff are expected to ensure that medications are ordered to treat a diagnosed condition. R #119 F. Record review of R #119's admission record, no date, revealed the following: 1. R #119 was admitted to the facility on [DATE]. 2. R #119 did not have a psychiatric diagnosis. G. Record review of R #119's physician's orders revealed an order dated 04/29/25, for trazadone (antidepressant medication) 25 mg as needed (PRN) for sleep related to systolic (congestive) heart failure (CHF, occurs when the heart's left ventricle cannot contract effectively, leading to insufficient blood being pumped to the body), ordered for indefinite time period (no end date). H. Record review of R #119's MAR's, dated April and May 2025, revealed that R #119 received PRN trazadone on 05/07/25 at 9:34 PM. I. Record review of R #119's entire medical record, no date, revealed the provider did not document a rationale for why R #119 needed to have a PRN order for trazadone for longer than 14 days. (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	J. On 05/19/25 at 2:12 PM, during an interview, the DON confirmed the following: 1. R #119 had an order for trazadone for sleep related to CHF. 2. R #119 did not have a psychiatric diagnosis for the use of trazadone. 3. R #119's PRN order for trazadone was ordered indefinitely. 4. Staff are expected to ensure there is a psychiatric diagnosis for the psychotropic medications that are ordered. 5. PRN psychotropic medications are not supposed to be ordered for longer than 14 days without a rationale for why it is needed. Gradual Dose Reduction R #9 K. Record review of R #9's admission record, no date revealed the following: 1. R #9 was admitted to the facility on [DATE]. 2. R #9 had a diagnosis of Anxiety disorder (mental health condition characterized by excessive fear, worry, and anxiety that interfere with daily life). L. Record review of R #9's physician's orders revealed an order for sertraline tablet (antidepressant medication used to treat anxiety and depression disorders) give 50 mg by mouth one time a day for anxiety. Start date: 09/16/24. M. Record review of R #9's MAR, dated 05/01/25 through 05/19/25, revealed the following: 1. On 05/01/25, R #9 received sertraline 50 mg in the morning. 2. On 05/02/25, R #9 received sertraline 50 mg in the morning. 3. On 05/03/25, R #9 received sertraline 50 mg in the morning 4. On 05/04/25, R #9 received sertraline 50 mg in the morning. 5. On 05/05/25, R #9 received sertraline 50 mg in the morning. 6. On 05/06/25, R #9 received sertraline 50 mg in the morning. 7. On 05/07/25, R #9 received sertraline 50 mg in the morning. 8. On 05/08/25, R #9 received sertraline 50 mg in the morning. 9. On 05/09/25, R #9 received sertraline 50 mg in the morning. (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	10. On 05/10/25, R #9 received sertraline 50 mg in the morning. 11. On 05/11/25, R #9 received sertraline 50 mg in the morning. 12. On 05/12/25, R #9 received sertraline 50 mg in the morning. 13. On 05/13/25, R #9 received sertraline 50 mg in the morning. 14. On 05/14/25, R #9 received sertraline 50 mg in the morning. 15. On 05/15/25, R #9 received sertraline 50 mg in the morning. 16. On 05/16/25, R #9 received sertraline 50 mg in the morning. 17. On 05/17/25, R #9 received sertraline 50 mg in the morning. 18. On 05/18/25, R #9 received sertraline 50 mg in the morning. 19. On 05/19/25, R #9 received sertraline 50 mg in the morning. N. Record review of R #9's Note to attending physician/prescriber (form that documents pharmacist recommendation regarding residents' medication(s)) to the physician/prescriber dated 03/03/25, revealed the following: 1. R #9 has been taking the antidepressant sertraline 50 mg once daily for anxiety since 09/17/24. Please evaluate the current dose and consider a dose reduction (GDR). 2. The form had Resident with good response, maintain the current dose and Disagree marked. 3. The medical director (clinician who oversees and guides the care provider to nursing home residents) did not provide rationale with patient specific information as to why R #10 needed to remain on the medication. 4. The form was signed by the medical director and dated 03/23/25. O. On 05/19/25 at 3:50 PM during an interview, the DON confirmed the following: 1. R #9 has not had a GDR for sertraline. 2. The medical director did not provide a rationale for not performing a GDR for R #9's sertraline. R #10 P. Record review of R #10's admission record, no date, revealed the following: 1. R #10 was admitted to the facility on [DATE]. (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. R #10 had the following psychiatric diagnoses: a. Depression (mood disorder that causes a persistent feeling of sadness and loss of interest). b. Restlessness and agitation (feelings of irritability, nervousness and mental distress). Q. Record review of R #10's physician's orders, multiple dates, revealed the following: 1. Order dated 04/11/24 and discontinued 11/26/24, for sertraline tablet (antidepressant medication used to treat anxiety and depression disorders) 50 mg, give 1 tablet by mouth in the morning related to depression. 2. Order dated 11/27/24 for sertraline tablet 50 mg, give 1 tablet by mouth in the morning for depression as evidenced by sadness. 3. Order dated 04/08/24 and discontinued 11/26/24, for trazodone tablet give 50 mg by mouth at bedtime for insomnia (common sleep disorder that makes it hard to fall asleep or stay asleep). 4. Order dated 11/27/24 for trazodone tablet give 50 mg by mouth at bedtime for insomnia. 5. Order dated 06/09/24 and discontinued 11/26/24, for escitalopram tablet (antidepressant medication used to treat anxiety and depression disorders) 10 mg, give 2 tablets by mouth in the morning for depression. 6. Order dated 11/27/24 for escitalopram tablet 10 mg, give 2 tablets by mouth in the morning for depression as evidenced by social isolation. 7. Order dated 04/22/24 and discontinued 11/26/24, hydroxyzine tablet (prescription-only antihistamine [medication with sedating and calming effect] that is used to treat anxiety) 10 mg, give 1 tablet by mouth two times a day for anxiety related to restlessness and agitation. 8. Order dated 11/27/24 hydroxyzine tablet 10 mg, give 1 tablet by mouth two times a day for anxiety as evidenced by restlessness and agitation. R. Record review of R #10's MAR, dated 05/01/25 through 05/19/25, revealed the following: Sertraline 1. On 05/01/25, R #10 received sertraline 50 mg in the morning. 2. On 05/02/25, R #10 received sertraline 50 mg in the morning. 3. On 05/03/25, R #10 received sertraline 50 mg in the morning 4. On 05/04/25, R #10 received sertraline 50 mg in the morning. 5. On 05/05/25, R #10 received sertraline 50 mg in the morning. (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	6. On 05/06/25, R #10 received sertraline 50 mg in the morning. 7. On 05/07/25, R #10 received sertraline 50 mg in the morning. 8. On 05/08/25, R #10 received sertraline 50 mg in the morning. 9. On 05/09/25, R #10 received sertraline 50 mg in the morning. 10. On 05/10/25, R #10 received sertraline 50 mg in the morning. 11. On 05/11/25, R #10 received sertraline 50 mg in the morning. 12. On 05/12/25, R #10 received sertraline 50 mg in the morning. 13. On 05/13/25 R #10 received sertraline 50 mg in the morning. 14. On 05/14/25, R #10 received sertraline 50 mg in the morning. 15. On 05/15/25, R #10 received sertraline 50 mg in the morning. 16. On 05/16/25, R #10 received sertraline 50 mg in the morning. 17. On 05/17/25, R #10 received sertraline 50 mg in the morning. 18. On 05/18/25, R #10 received sertraline 50 mg in the morning. 19. On 05/19/25, R #10 received sertraline 50 mg in the morning. Trazodone 20. On 05/01/25, R #10 received trazodone 50 mg in the evening. 21. On 05/02/25, R #10 received trazodone 50 mg in the evening. 22. On 05/03/25, R #10 received trazodone 50 mg in the evening. 23. On 05/04/25, R #10 received trazodone 50 mg in the evening. 24. On 05/04/25, R #10 received trazodone 50 mg in the evening. 25. On 05/06/25, R #10 received trazodone 50 mg in the evening. 26. On 05/07/25, R #10 received trazodone 50 mg in the evening. 27. On 05/08/25, R #10 received trazodone 50 mg in the evening. 28. On 05/09/25, R #10 received trazodone 50 mg in the evening. (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	29. On 05/10/25, R #10 received trazodone 50 mg in the evening. . 30. On 05/11/25, R #10 received trazodone 50 mg in the evening. 31. On 05/12/25 R #10 received trazodone 50 mg in the evening. 32. On 05/13/25, R #10 received trazodone 50 mg in the evening. 33. On 05/14/25, R #10 received trazodone 50 mg in the evening. 34. On 05/15/25, R #10 received trazodone 50 mg in the evening. 35. On 05/16/25, R #10 received trazodone 50 mg in the evening. 36. On 05/17/25, R #10 received trazodone 50 mg in the evening. 37. On 05/18/25, R #10 received trazodone 50 mg in the evening. Escitalopram 38. On 05/01/25, R #10 received escitalopram 20 mg in the morning. 39. On 05/02/25, R #10 received escitalopram 20 mg in the morning. 40. On 05/03/25, R #10 received escitalopram 20 mg in the morning. 41. On 05/04/25, R #10 received escitalopram 20 mg in the morning. 42. On 05/05/25, R #10 received escitalopram 20 mg in the morning. 43. On 05/06/25, R #10 received escitalopram 20 mg in the morning. 44. On 05/07/25, R #10 received escitalopram 20 mg in the morning. 45. On 05/08/25, R #10 received escitalopram 20 mg in the morning. 46. On 05/09/25, R #10 received escitalopram 20 mg in the morning. 47. On 05/10/25, R #10 received escitalopram 20 mg in the morning. 48. On 05/11/25, R #10 received escitalopram 20 mg in the morning. 49. On 05/12/25, R #10 received escitalopram 20 mg in the morning. 50. On 05/13/25 R #10 received escitalopram 20 mg in the morning. 51. On 05/14/25, R #10 received escitalopram 20 mg in the morning. (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	52. On 05/15/25, R #10 received escitalopram 20 mg in the morning. 53. On 05/16/25, R #10 received escitalopram 20 mg in the morning. 54. On 05/17/25, R #10 received escitalopram 20 mg in the morning. 55. On 05/18/25, R #10 received escitalopram 20 mg in the morning. 56. On 05/19/25, R #10 received escitalopram 20 mg in the morning. Hydroxyzine 57. On 05/01/25, R #10 received hydroxyzine 10 mg twice daily. 58. On 05/02/25, R #10 received hydroxyzine 10 mg twice daily. 59. On 05/03/25, R #10 received hydroxyzine 10 mg twice daily. 60. On 05/04/25, R #10 received hydroxyzine 10 mg twice daily. 61. On 05/05/25, R #10 received hydroxyzine 10 mg twice daily. 62. On 05/06/25, R #10 received hydroxyzine 10 mg twice daily. 63. On 05/07/25, R #10 received hydroxyzine 10 mg twice daily. 64. On 05/08/25, R #10 received hydroxyzine 10 mg twice daily. 65. On 05/09/25, R #10 received hydroxyzine 10 mg twice daily. 66. On 05/10/25, R #10 received hydroxyzine 10 mg twice daily. 67. On 05/11/25, R #10 received hydroxyzine 10 mg twice daily. 68. On 05/12/25, R #10 received hydroxyzine 10 mg twice daily. 69. On 05/13/25, R #10 received hydroxyzine 10 mg twice daily. 70. On 05/14/25, R #10 received hydroxyzine 10 mg twice daily. 71. On 05/15/25, R #10 received hydroxyzine 10 mg twice daily. 72. On 05/16/25, R #10 received hydroxyzine 10 mg twice daily. 73. On 05/17/25, R #10 received hydroxyzine 10 mg twice daily. 74. On 05/18/25, R #10 received hydroxyzine 10 mg twice daily. (continued on next page)

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

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	S. Record review of R #10's Recommendation Summary for DON and medical director dated 02/03/25, revealed the following: 1. R #10 has a history of chronic depression and has been receiving the current dose sertraline 50 mg every morning since 04/11/24, trazodone 50 mg at bedtime since 04/08/24, and escitalopram 20 mg every morning since 06/09/24 2. Federal guidelines require assessment of medication therapy showing benefit to risk for continuing therapy and periodic dose reduction trials when medications may no longer be necessary. Please check the appropriate response and add additional information as requested. 3. The form had Patient has had good response to treatment and requires this dose for condition stability. Dose reduction is contraindicated because benefits outweigh risks for this patient at this time and a reduction is likely to impair the residents function and or cause psychiatric instability. Please elaborate with patient specific information marked. 4. The medical director did not provide rationale with patient specific information as to why R #10 needed to remain on the medications. 5. The form was signed by the medial director and dated 03/23/25. T. Record review of R #10's Note to attending physician/prescriber dated 04/01/25, revealed the following: 1. R #10 has been taking the anxiolytic (class of medications used to prevent or treat anxiety symptoms or disorders) hydroxyzine 10 mg twice daily for anxiety since 04/22/24. Please evaluate the current dose and consider a dose reduction. 2. The form had Resident with good response, maintain the current dose marked. 3. The medical director did not provide rationale with patient specific information as to why R #10 needed to remain on the same dose of hydroxyzine. 4. The form was signed by the medical director and dated 04/03/25. U. On 05/19/25 at 3:57 PM, during an interview, the DON confirmed the following: 1. R #10 has not had a GDR for sertraline, trazodone, escitalopram, and hydroxyzine. 2. The medical director did not provide a rationale for not performing GDR's for R #10's medications. R #11 V. Record review of R #11's admission record, no date, revealed the following: 1. R #11 was admitted to the facility on [DATE]. (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. R #11 had the following psychiatric diagnoses: a. Major Depressive Disorder (MDD, mental health disorder characterized by persistently depressed mood or loss of interest in activities, causing significant impairment in daily life) b. Panic disorder [Episodic Paroxysmal Anxiety] (mental and behavioral disorder, specifically an anxiety disorder characterized by recurring unexpected panic attacks). c. Psychotic Disorder with Hallucinations due to known physiological condition (a condition when people lose some contact with reality. This might involve seeing or hearing things that other people cannot see or hear (hallucinations) and believing things that are not actually true (delusions)). d. Insomnia (a common sleep disorder that can make it hard to fall asleep or stay asleep). W. Record review of R #11's physician's orders, multiple dates, revealed the following: 1. Order dated 04/29/24 and discontinued 11/26/24, for buspirone (medication that can treat anxiety) 5 mg tablet, one tablet twice a day for anxiety. 2. Order dated 11/26/24, for buspirone 5 mg tablet, one tablet twice a day for anxiety. 3. Order dated 09/29/23 and discontinued 11/26/24, for lorazepam 0.5 mg tablet, one tablet twice a day for anxiety. 4. Order dated 11/26/24, for lorazepam (medication that can treat anxiety) 0.5 mg tablet, one tablet twice a day for anxiety. 5. Order dated 07/07/23 and discontinued 10/01/23, for trazadone 50 mg, one tablet in the evening for insomnia. 6. Order dated 10/01/23 and discontinued 11/26/24, for trazadone 50 mg, one tablet in the evening for depression, MDD, insomnia. 7. Order dated 11/26/24, for trazadone 50 mg tablet, one tablet in the evening for depression, MDD, insomnia. 8. Order dated 08/03/23 and discontinued 11/26/24, for mirtazapine 7.5 mg, give 1/2 of 15 mg tablet in the evening for depression. 9. Order dated 11/26/24, for mirtazapine 7.5 mg, give 1/2 of 15 mg tablet in the evening for depression. 10. Order dated 06/30/23, for Nuplazid 34 mg, give one capsule at bedtime for hallucinations related to Parkinson's disease (psychotic disorder with hallucinations due to known physiological condition). X. Record review of R #11's MAR, dated May 2025, revealed the following: (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1. R #11 received Lorazepam 0.5 mg twice a day as ordered. 2. R #11 received buspirone 5 mg twice a day as ordered. 3. R #11 received trazadone 50 mg in the evening as ordered. 4. R #11 received mirtazapine 7.5 mg in the evening as ordered. 5. R #11 received Nuplazid 34 mg in the evening as ordered. Y. Record review of of the Psychotropic & Sedative/Hypnotic Utilization By Resident report (pharmacist spreadsheet that includes information about the use of psychotropic, sedative, and hypnotic medications), dated 05/02/25, revealed the following: 1. R #11 had an order for buspirone 5 mg twice a day since 04/29/24, and a GDR was declined in February 2025. 2. R #11 had an order for lorazepam 0.5 mg twice a day since 09/29/23, and a GDR was declined in September 2024. 3. R #11 had an order for mirtazapine (antidepressant medication) 7.5 mg in the evening for depression since 08/03/23, and a GDR was declined in September 2024. 4. R #11 had an order for Nuplazid 34 mg at bedtime since 06/30/23, and a GDR was recommended in April 2025. 5. R #11 had an order for trazadone 50 mg at bedtime since 10/01/23, and a GDR was declined in October 2024. Z. Record review of R #11's pharmacist recommendation, dated 08/03/24, revealed the following: 1. R #11 has a history of chronic depression and has been receiving the current dose of mirtazapine 7.5 mg in the evening for depression since 08/03/23. Federal guidelines require assessment of medication therapy showing benefit to risk for continuing therapy and periodic dose reduction trials when medications may no longer be necessary. Please check the appropriate response and add additional information as requested: 2. The form had Patient has had a good response to treatment and requires this dose for condition stability. Dose reduction is contraindicated because benefits outweigh risks for this patient at this time and a reduction is likely to impair the resident's function and/or cause psychiatric instability. (Please elaborate with patient specific information) selected. 3. The form had agree selected with a provider signature and date of 09/15/24. 4. R #11's physician did not provide rationale with patient specific information as to why resident needed to remain on medication. AA. Record review of R #11's pharmacist recommendation, dated 09/03/24, revealed the following: (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1. R #11 has been taking the anxiolytic lorazepam 0.5 mg twice daily since 09/28/23. Please evaluate the current dose and consider a dose reduction. 2. The form had agree selected with a signature and date of 09/09/24. 3. The form had a note dated 09/16/24, verbal order to continue med. Per order by [Doctor Name]. 4. R #11's physician did not provide rationale with patient specific information as to why resident needed to remain on medication. BB. Record review of R #11's pharmacist recommendation, dated 10/04/24, revealed the following: 1. R #11 has a history of chronic depression and has been receiving the current dose of trazadone 50 mg at bedtime for depression since 10/01/23. Federal guidelines require assessment of medication therapy showing benefit to risk for continuing therapy and periodic dose reduction trials when medications may no longer be necessary. Please check the appropriate response and add additional information as requested: 2. The form had Patient has had a good response to treatment and requires this dose for condition stability. Dose reduction is contraindicated because benefits outweigh risks for this patient at this time and a reduction is likely to impair the resident's function and/or cause psychiatric instability. (Please elaborate with patient specific information) selected. 3. R #11's physician did not provide rationale with patient specific information as to why resident needed to remain on medication. 4. The form had a note, dated 10/14/24, [Name of nurse practitioner] verbal continue of this dose. CC. Record review of R #11's pharmacist recommendation, dated 02/03/25, revealed the following: 1. R #11 has been taking the anxiolytic buspirone 5 mg since 04/29/24. Please evaluate the current dose and consider a dose reduction (GDR). 2. The form had Condition stable: Attempt dose reduction to discontinue this medication, Resident with good response, maintain the current dose, and Disagree marked. 3. R #11's physician did not provide rationale with patient specific information as to why resident needed to remain on medication. 4. The form had a comment dated 02/19/25, MD intended to keep resident on current dose, verified by [DON signature]. DD. Record review of R #11's pharmacist recommendation, dated 04/05/25, revealed the following: 1. R #11 has been taking the antipsychotic Nuplazid 34 mg at bedtime for psychotic disorder with hallucinations related to Parkinson's Disease since 06/30/23. Please evaluate the current dose and consider a dose reduction. (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. The form had Resident with good response, maintain the current dose. 3. The form had agree selected with a signature and date of 05/09/25. 4. R #11's physician did not provide rationale with patient specific information as to why resident needed to remain on medication. EE. On 05/19/25 at at 2:34 during an interview, the DON confirmed the following: 1. R #11 has not had a GDR for buspirone, lorazepam, mirtazapine, trazadone, or Nuplazid. 2. The provider did not provide a rationale for why she did not perform a GDR for R #11 for buspirone, lorazepam, mirtazapine, trazadone, or Nuplazid. R #118 FF. Record review of R #118's physician's orders, multiple dates, revealed the following: 1. An order dated 07/15/24 and discontinued on 05/13/25, for Mirtazapine 7.5 mg in the evening for appetite and depression. 2. An order dated 05/13/25, for Mirtazapine 7.5 mg in the evening for appetite and depression. GG. Record review of R #118's MAR, dated 05/01/25 through 05/12/25, revealed the following: 1. On 05/01/25, R #118 received mirtazapine 7.5 mg in the evening. 2. On 05/02/25, R #118 received mirtazapine 7.5 mg in the evening. 3. On 05/03/25, R #118 refused mirtazapine 7.5 mg in the evening. 4. On 05/04/25, R #118 refused mirtazapine 7.5 mg in the evening. 5. On 05/05/25, R #118 received mirtazapine 7.5 mg in the evening. 6. On 05/06/25, R #118 received mirtazapine 7.5 mg in the evening. 7. On 05/07/25, R #118 received mirtazapine 7.5 mg in the evening. 8. On 05/08/25, R #118 received mirtazapine 7.5 mg in the evening. 9. On 05/09/25, R #118 received mirtazapine 7.5 mg in the evening. 10. On 05/10/25, R #118 received mirtazapine 7.5 mg in the evening. 11. On 05/11/25, R #118 received mirtazapine 7.5 mg in the evening. 12. On 05/12/25, R #118 refused mirtazapine 7.5 mg in the evening. (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	HH. Record review R #118's pharmacist recommendation, dated 05/02/25, revealed the following: 1. R #118 has a history of chronic depression and has been receiving the current dose of mirtazapine 7.5 mg in the evening for depression since 07/15/24. Federal guidelines require assessment of medication therapy showing benefit to risk for continuing therapy and periodic dose reduction trials when medications may no longer be necessary. Please check the appropriate response and add additional information as requested: 2. The form had Patient has had a good response to treatment and requires this dose for condition stability. Dose reduction is contraindicated because benefits outweigh risks for this patient at this time and a reduction is likely to impair the resident's function and/or cause psychiatric instability. (Please elaborate with patient specific information) selected. 3. The form a provider signature and date of 05/09/25. 4. R #11's physician did not provide rationale with patient specific information as to why resident needed to remain on medication. II. On 05/19/25 at 2:16 PM, during an interview, the DON confirmed the following: 1. R #118 has not had a GDR for mirtazapine. 2. The provider did not provide a rationale for why she did not perform a GDR for R #118 for mirtazapine. Excessive Sedation R #130 JJ. Record review of R #130's admission record, no date, revealed the following: 1. R #130 was admitted to the facility on [DATE]. 2. R #130 had the following psychiatric diagnoses: a. Other specified anxiety disorder (diagnosis that applies to individuals who have symptoms characteristic of an anxiety disorder such as excessive fear, worry, and anxiety that interfere with daily life but do not meet the criteria for a specific anxiety disorder). b. Depression, unspecified (diagnosis used when someone displays depressive symptoms such as feelings of sadness or loss of interest but there is not enough information for a specific diagnosis) KK. On 05/13/25 at 10:04 AM, during an interview, R #130 stated that she was very sleepy, and she did not know why. R #130 stated she slept well last night. LL. On 05/14/25 at 9:44 AM, during an observation of the common area (TV room), R #130 was asleep in her wheelchair. (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	MM. On 05/14/25 at 2:15 PM, during an observation of R #130, she was asleep on her recliner in her room. NN. On 05/15/25 at 1:30 PM, during an observation of R #130, she was asleep on her recliner in her room. R #130's lunch tray was on the bathroom counter and appeared to be untouched. OO. On 05/15/25 at 1:32 PM, during an interview, R #130's POA (power of attorney) stated the following: 1. R #130 was asleep since she arrived at 11:00 AM. 2. R #130 was slumped over in her wheelchair asleep in the common area. 3. She asked the facility staff to assist her in taking R #130 to her room and assist her into her recliner. 4. She and R #130's other family members have noticed that R #130 has been sleeping more during the daytime hours. 5. R #130 was too sleepy and did not eat any of her lunch. 6. She was not aware that R #130 was taking her Xanax (name brand of antianxiety medication alprazolam; medication primarily used to treat anxiety disorders and anxiety associated with depression) three times daily and was not aware that R #130 was also taking hydroxyzine (prescription-only antihistamine [medication with sedating and calming effect] that is used to treat anxiety) twice daily. 7. R #130 was only taking Xanax as needed prior to her admission to the facility, R #130's POA stated she usually gave R #130 Xanax in the morning and sometimes at 1:00 PM. PP. Record review of R #130's admission referral dated 04/08/25 revealed the following: 1. Diagnosis; anxiety, depression. 2. Alprazolam 0.25 mg give one tablet by mouth three times daily as needed for anxiety. QQ. Record review of R #130's physician's orders revealed the following: 1. An order for alprazolam (generic for Xanax) 0.25 mg, give 1 tablet by mouth three times daily (7:00 AM, 1:00 PM, and 8:00 PM) for anxiety and restlessness. Start date 04/16/25. 2. An order for hydroxyzine tablet 25 mg, give one tablet by mouth two times daily related to anxiety. Start date: 04/19/25 RR. Record review of R #130's MAR, dated 05/01/25 through 05/18/25, revealed the following: Alprazolam 1. On 05/01/25, R #130 received alprazolam 0.25 mg three times daily. (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. On 05/02/25, R #130 received alprazolam 0.25 mg three times daily. 3. On 05/03/25, R #130 received alprazolam 0.25 mg three times daily. 4. On 05/04/25, R #130 received alprazolam 0.25 mg three times daily. 5. On 05/05/25, R #130 received alprazolam 0.25 mg three times daily. 6. On 05/06/25, R #130 received alprazolam 0.25 mg three times daily. 7. On 05/07/25, R #130 received alprazolam 0.25 mg three times daily. 8. On 05/08/25, R #130 received alprazolam 0.25 mg three times daily. 9. On 05/09/25, R #130 received alprazolam 0.25 mg three times daily. 10. On 05/10/25, R #130 received alprazolam 0.25 mg three times daily. 11. On 05/11/25, R #130 received alprazolam 0.25 mg three times daily. 12. On 05/12/25, R #130 received alprazolam 0.25 mg three times daily. 13. On 05/13/25 R #130 received alprazolam 0.25 mg three times daily. 14. On 05/14/25, R #130 received alprazolam 0.25 mg three times daily. 15. On 05/15/25, R #130 received alprazolam 0.25 mg three times daily. 16. On 05/16/25, R #130 received alprazolam 0.25 mg three times daily. 17. On 05/17/25, R #130 received alprazolam 0.25 mg three times daily. 18. On 05/18/25, R #130 received alprazolam 0.25 mg three times daily. Hydroxyzine 19. On 05/01/25, R #130 received hydroxyzine 25 mg twice daily. 20. On 05/02/25, R #130 received hydroxyzine 25 mg twice daily. 21. On 05/03

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 49313 Based on record review and interview, the facility failed to provide the required discharge or transfer information to the resident and the resident's representative(s) in writing for 3 (R #8, R #11, and R #119) of 3 (R #8, R #11, and R #119) residents sampled for hospitalization s or discharge when staff failed to: 1. Notify the resident and the resident's representative of the plan to discharge the resident from the facility in writing and in a language and manner they understand for R #8. 2. Complete a discharge summary for R #8 that included the following: a. A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results. b. A final summary of the resident's status including an accurate and current description of the clinical status of the resident and sufficiently detailed, individualized care instructions, to ensure that care is coordinated and the resident transitions safely from one setting to another. c. A reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter) 3. Notify the residents and resident's representative(s) of the resident's transfer to the hospital in writing and in a language and manner they understand for R #11 and R #119. 4. Ensure the transfer or discharge notice for R #8, R #11, and R #119 included: a. A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request. b. The name, phone number, and address (mailing and email) of the Office of the State Long-Term Care Ombudsman. 5. Send a written copy of the Discharge or Transfer Notices to the Ombudsman for R #8, R #11, and R #119. 6. Ensure R #119 or his representative received a written notice of the bed hold policy which indicated the duration the bed would be held. These deficient practices could likely result in the resident and/or their representative not knowing the reason for a transfer or discharge, the location of the transfer or discharge their rights to advocate and make informed decisions regarding the resident's healthcare, the services that the resident received while at the facility, the resident's current health status, or the resident's current medications leading to adverse outcomes for the resident. The findings are: (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Discharge Notices R #8 A. Record review of R #8's medical record, no date, revealed the following: 1. R #8 was admitted to the facility on [DATE]. 2. R #8 was discharged from the facility on 03/14/25. B. Record review of R #8's progress note, dated 03/14/25, revealed the following: 1. R #8 was discharged home with family. 2. R #8 was given her medications and copies of her paperwork. 3. R #8 and her family were educated on how to take her medications and what they were for. 4. R #8's vital signs were normal and she had no pain. C. Record review of R #8's entire medical record, no date, revealed staff did not document the following: 1. A discharge notice for R #8's discharge from the facility on 03/14/25. 2. A discharge summary for R #8. D. On 05/15/25 at 2:40 PM, during an interview, RN #16 stated the following regarding discharging residents: 1. They complete an assessment on the resident. 2. She stated they do not complete a discharge summary or a recapitulation of the resident's stay. 3. The nurses educate the resident and their family about medications that the resident was taking in the facility and give them a printout of facility medications. 4. They educate the resident and family about any upcoming appointments. E. On 05/15/25 at 3:14 PM, during an interview, the Ombudsman stated that she did not receive a discharge notice for R #8's discharge on 03/14/25. F. On 05/19/25 at 2:27 PM, during an interview, the DON confirmed the following: 1. R #8 discharged to her home on 3/14/25. (continued on next page)

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

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. R #8's medical record did not contain documentation of discharge summary, discharge notification, recapitulation of stay, or medication reconciliation. 3. The facility did not send a written copy of a discharge notification for R #8 to the Ombudsman. Transfer and Behold Notices R #11 G. Record review of R #11's medical record revealed the following: 1. On 04/16/25, R #11 was sent to the hospital after a fall. 2. The medical record did not contain a written transfer notice for R #11's transfer to the hospital on 04/16/25. R #119 H. Record review of R #119's medical record revealed the following: 1. On 05/08/25, R #119 was sent to the hospital after a fall. 2. The medical record did not contain a written transfer notification for R #119's transfer to the hospital on 05/08/25. 3. The medical record did not contain a written bed hold notification for R #119's transfer to the hospital on 05/08/25. I. On 05/16/25 at 10:34 AM, during an interview, the Business Office Manager (BOM), stated the following: 1. She does not complete transfer notices. 2. She is responsible for completing bed hold notifications for residents. 3. She did not complete a bed hold notification for R #119's transfer to the hospital on 05/08/25. J. On 05/16/25 at 10:58 AM, during an interview, the DON confirmed the following: 1. Staff were not completing written transfer or discharge notices when residents transfer or discharge from the facility. 2. Staff were not providing a copy of written transfer or discharge notices to the ombudsman. 3. The BOM is expected to complete bed hold notifications when residents are transferred to the hospital.

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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** 52223 Recite from 05/22/24 Based on record review and interview, the facility failed to ensure a comprehensive MDS was completed within 14 calendar days after admission for 1 (R #12) of 9 (R #1, R #2, R #3, R #4, R #5, R #6, R #9, R #11, and R #12) residents reviewed for MDS. This deficient practice could likely result in residents' care needs not being met. The findings are: A. Record review of R #12's Admission record no date revealed an admitted [DATE]. B. Record review of R #12's Admission MDS assessment dated [DATE] revealed the Admission MDS assessment was accepted on 01/06/25. C. On 05/19/25 at 1:21 PM, during an interview with the MDS Coordinator, she confirmed R #12's Admission MDS assessment was not completed within 14 days of admission. The MDS Coordinator confirmed that the Admission MDS assessments should be completed within 14 days of admission.

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident when there is a significant change in condition **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 52223 Based on record review and interview, the facility failed to complete a significant change (major decline or improvement in the patient's health status) MDS Set assessment within 14 days after the facility determined a significant change in the resident's physical or mental condition for 1 (R #3) of 9 (R #1, R #2, R #3, R #4, R #5, R #6, R # 9, R #11, and R #12) resident reviewed for MDS. This deficient practice could likely result in the residents not receiving the appropriate care and services they need. The findings are: A. Record review of R #3's Admission record no date revealed an admitted [DATE]. B. Record review of R #3's physician orders dated 03/26/25 revealed an order for palliative care (an interdisciplinary medical care-giving approach aimed at optimizing quality of life and mitigating or reducing suffering among people with serious, complex, and often terminal illnesses). C. Record review of R #3's nursing progress note dated 03/26/25 revealed R #3 was placed on Palliative Care due to R #3 declining and failure to thrive. D. Record review of R #3's significant change of condition MDS assessment dated [DATE], revealed the MDS assessment was not completed and signed off by the RN until 04/10/25, and accepted on 04/21/25. E On 05/19/25 at 1:21 PM, during an interview with the MDS coordinator, she confirmed R #3's physicians orders for palliative care on 03/26/25, and the significant change MDS assessment for R #3 was not completed within 14 days from the determination date of 03/26/25 when resident was placed on palliative care. The MDS Coordinator confirmed that the significant change MDS assessments should be completed within 14 days of change of condition.

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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. 52223 Based on record review and interview, the facility failed to ensure that an MDS was completed every three months for 2 (R #1, and R #9) of 9 (R #1, R #2, R #3, R #4, R #5, R #6, R #9, R #11, and R #12) resident reviewed for MDS assessments, when they failed to complete quarterly MDS assessments timely (completed 92 days after the previous assessment reference date (ARD)). This failed 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 #1's quarterly MDS assessments revealed the following: 1. Quarterly MDS accepted 01/06/25. 2. Quarterly MDS accepted 04/07/25. B. Record review of R #9's quarterly MDS assessments revealed the following: 1. Quarterly MDS accepted 01/06/25. 2. Quarterly MDS accepted 04/13/25. D. On 05/19/25 at 1:21 PM, during an interview with the MDS Coordinator confirmed that R #1's, and R #9's, Quarterly MDS assessments were not completed on time.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 52223 Based on record review and interview, the facility failed to have MDS assessments completed, submitted, and finalized in a timely manner (within 14 days of completion) for 9 (R #1, R #2, R #3, R #4, R #5, R #6, R #9, R #11, and R #12) of 9 (R #1, R #2, R #3, R #4, R #5, R #6, R #9, R #11, and R #12) residents reviewed for MDS assessments. If MDS assessments are not completed, submitted, and finalized in a timely manner, it is likely that residents will receive less than optimal care. The findings are: R #1 A. Record review of R #1's Admission record revealed that R #1 was admitted on [DATE]. B. Record review of the MDS 3.0 Missing OBRA Assessment Report for R #1 revealed R #1 MDS target date (Assessment Reference Date) on 12/25/24 and was not received. R #2 C. Record review of R #2's Admission record revealed that R #2 was admitted on [DATE]. D. Record review of the MDS 3.0 Missing OBRA Assessment Report for R #2 revealed R #2 MDS target date on 01/01/25 and was not received. R #3 E. Record review of R #3's Admission record revealed that R #3 was admitted on [DATE]. F. Record review of the MDS 3.0 Missing OBRA Assessment Report for R #3 revealed R #3 MDS target date on 08/28/24 and was not received. R #4 G. Record review of R #4's Admission record revealed that R #4 was admitted on [DATE]. H. Record review of the MDS 3.0 Missing OBRA Assessment Report for R #4 revealed R #4 MDS target date on 12/18/24 and was not received. R #5 I. Record review of R #5's Admission record revealed that R #5 was admitted on [DATE]. J. Record review of the MDS 3.0 Missing OBRA Assessment Report for R #5 revealed R #5 MDS target date on 12/18/24 and was not received. R #6 (continued on next page)

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F 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	K. Record review of R #6's Admission record revealed that R #6 was admitted on [DATE]. L. Record review of the MDS 3.0 Missing OBRA Assessment Report R #6 revealed R #6 MDS target date on 12/18/24 and was not received. R #9 M. Record review of R #9's Admission record revealed that R #9 was admitted on [DATE]. N. Record review of the MDS 3.0 Missing OBRA Assessment Report for R #9 revealed R #9 MDS target date on 12/18/24 and was not received. R #11 O. Record review of R #11's Admission record revealed that R #11 was admitted on [DATE]. P. Record review of the MDS 3.0 Missing OBRA Assessment Report for R #11 revealed R #11 MDS target date on 01/01/25 and was not received. R #12 Q. Record review of R #12's Admission record revealed that R #12 was admitted on [DATE]. R. Record review of the MDS 3.0 Missing OBRA Assessment Report for R #12 revealed R #12 MDS target date on 12/24/24 and was not received. S. On 05/19/25 at 1:21 PM, during an interview with the MDS coordinator, she confirmed that she wasn't sure why the MDS Assessments were not being submitted on time, and stated she would consult the facilities MDS Consultant for directions. T. On 05/22/25 at 9:52 AM, during an interview with the State Agency MDS Coordinator, she confirmed that the MDS 3.0 Missing OBRA Assessment Report showed that the MDS Assessments have not been received from the facility and the facility was sent error messages related to the assessments.

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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** 41755 Based on interview and record review, the facility failed to ensure the Minimum Data Set Assessment were accurate for 3 (R #9, R #118 and R #121) of 9 (R #1, R #4, R #9, R #10, R #118, R #119, R #121, R #130 and R #131) 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 #9 A. Record review of R #9's admission record revealed R #9 was admitted on [DATE]. B. Record review of R #9's physician's orders revealed an order for Smaglutide (non-insulin medication used to help improve blood sugar control) subcutaneous (fatty tissue layer just beneath the skin) solution, inject 1 mg every Sunday for diabetes mellitus type 2 (DM 2; chronic disease characterized by high levels of sugar in the blood). Start date: 12/08/24. C. Record review of R #9's Quarterly MDS dated [DATE] revealed the following: 1. Section N0350, Insulin (hormone that helps lower blood sugar levels) a. Staff documented R #9 received 1 insulin injection in the last 7 days. D. Record review of R #9's MAR for March 2025 revealed the following: 1. R #9 received semaglutide injection on 03/09/25 2. R #9 did not receive any insulin injections. E. On 05/19/25 at 2:27 PM, during an interview, the MDS Coordinator confirmed that R #9 did receive semaglutide injection but did not receive any insulin injections. The MDS coordinator confirmed that R #9's Quarterly MDS was not accurate because R #9 did not receive any insulin injections. R #118 F. Record review of R #118's admission documents revealed the following: 1. R #118 was admitted to the facility on [DATE]. 2. R #118 had a diagnosis of muscle weakness. G. Record review of R #118's physician's order, dated 12/06/24, revealed R #118 had an order for Restorative Nursing Program (RNP), for bilateral (right and left side) arm and leg strengthening exercises once a day five days a week as tolerated. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	H. Record review of R #118's quarterly MDS assessment, dated 02/19/25, revealed staff documented the following: 1. Section O- Special Treatments, Procedures, and Programs. O0500. Restorative Nursing Programs Record the number of days each of the following restorative programs was performed for at least 15 minutes a day) in the last 7 calendar days (enter 0 if none or less than 15 minutes daily): a. Range of Motion (passive)- 0 bragged of Motion (active)- 0 c. Splint of brace assistance- 0 I. Record review of R #118's survey documentation report (report that includes documentation regarding activities of daily living, RNP, and other care areas provided for residents), dated February 2025, revealed R #118 received active range of motion (AROM, resident moves joints on their own) and passive range of motion (PROM, resident receives assistance with moving joints) as follows: 1. 02/01/25, 5 minutes of AROM and 5 minutes of PROM. 2. 02/02/25, 5 minutes of AROM and 5 minutes of PROM. 3. 02/03/25, 10 minutes of AROM and 10 minutes of PROM. 4. 02/04/25, 10 minutes of AROM and 10 minutes of PROM. 5. 02/05/25, 15 minutes of AROM and 15 minutes of PROM. 6. 02/06/25, 15 minutes of AROM and 15 minutes of PROM. 7. 02/07/25, 10 minutes of AROM and 10 minutes of PROM. 8. 02/08/25, 5 minutes of AROM and 5 minutes of PROM. 9. 02/09/25, 5 minutes of AROM and 5 minutes of PROM. 10. 02/10/25, 5 minutes of AROM and 5 minutes of PROM. 11. 02/11/25, 15 minutes of AROM and 15 minutes of PROM. 12. 02/12/25, 15 minutes of AROM and 15 minutes of PROM. 13. 02/13/25, 0 minutes of AROM and 15 minutes of PROM. 14. 02/14/25, 5 minutes of AROM and 5 minutes of PROM. 15. 02/17/25, 15 minutes of AROM and 15 minutes of PROM. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	16. 02/18/25, 15 minutes of AROM and 15 minutes of PROM. 17. 02/19/25, 5 minutes of AROM and 5 minutes of PROM. J. On 05/19/25 at 12:50 PM, during an interview, the MDS coordinator confirmed the following: 1. R #118 had received RNP services within the 7 days prior to the MDS assessment. 2. R #118's quarterly MDS, dated [DATE], showed that R #119 did not receive RNP services during the 7 days prior to the MDS assessment. 3. She should have included R #118's RNP services on the MDS assessment. R #121 K. Record review of R #121's admission documents revealed the following: 1. R #121 was admitted to the facility on [DATE]. 2. R #121 had a diagnosis of cellulitis (a common and potentially serious bacterial skin infection) of unspecified toe. L. Record review of R #121's skin assessment, dated 04/16/25, revealed the following: 1. R #121 had an open blister on her lower left leg. 2. R #121 had newly diagnosed cellulitis and was taking antibiotics. 3. R #121 had wound care orders. 4. R #121 did not have any pressure wounds. M. Record review of R #121's physician's orders, dated 04/16/25, revealed an order for wound care to left lower leg blister every day and as needed until healed. N. Record review of R #121's quarterly MDS assessment, dated 04/17/25, revealed Section M- Skin Conditions: M0300- Current Number of Unhealed Pressure Ulcers/Injuries at Each Stage- B. Stage 2 Partial thickness loss of dermis presenting as a shallow open ulcer with a red or pink wound bed, without slough. May also present as an intact or open/ruptured blister, staff documented that R #121 had one stage 2 pressure ulcer. O. On 05/19/25 at 12:39 PM, during an interview, the MDS Coordinator confirmed the following: 1. R #121 did not have any pressure ulcers. 2. R #121's quarterly MDS, dated [DATE], indicated that R #121 had a stage 2 pressure ulcer. 3. R #121's quarterly MDS was inaccurate because she did not have a pressure wound. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	49313

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49313 Based on record review and interview, the facility failed to create an accurate baseline care plan (minimum healthcare information necessary to properly care for a resident immediately upon their admission to the facility) for 1 (R #119) of 1 (R #119) resident reviewed for unnecessary medication use. This deficient practice could likely result in residents not receiving the appropriate care and may place residents at risk of an adverse event (undesirable experience, preventable or non-preventable, that caused harm to a resident because of medical care or lack of medical care) or worsening of current condition after admission. The findings are: A. Record review of R #119's Admission Record, no date, revealed R #119 was admitted into the facility on [DATE]. B. Record review of R #119's medication list from the hospital, no date, revealed an order for trazadone (antidepressant medication) 50 mg, give 0.5 mg as needed for sleep. C. Record review of R #119's physician's order, dated 04/29/25, revealed an order for trazadone 25 mg by mouth as needed for sleep related to systolic (congestive) heart failure (occurs when the heart's left ventricle cannot contract effectively, leading to insufficient blood being pumped to the body). D. Record review of R #119's baseline care plan, dated 04/29/25, revealed R #119's baseline care plan did not include R #119's order the antidepressant medication trazadone. E. On 05/19/25 at 2:12 PM, during an interview, the DON confirmed the following: 1. R #119 had an order for the antidepressant medication trazadone. 2. Antidepressant medication is a high-risk medication drug classification (medications that have a heightened risk of causing significant patient harm when they are used in error). 3. R #119's baseline care plan did not include R #119's order for trazadone. 4. Baseline care plan should include all high-risk medications.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41755 Recite from 05/22/24 Based on record review and interview, the facility failed to develop an accurate, person-centered comprehensive care plan for 2 (R #4 and R #9) of 12 (R #1, R #4, R #9, R #10, R #11, R #118, R #121, R #122, R #123, R #124, R #130 and R #131) residents reviewed for comprehensive care plans (plan that has measurable goals and timeframes to meet a resident's medical, nursing, mental health and psychosocial needs). This deficient practice could likely result in staff being unaware of the current and actual needs of the residents. The findings are: R #4 A. Record review of R #4's Admission record no date revealed an admitted [DATE]. B. Record review of R #4's MDS Assessment revealed the Annual MDS Assessment was completed on 09/18/24. The MDS included R #4's personal preferences for activities. C. Record review of R #4's care plan dated 09/30/24 revealed staff did not document on the care plan R #4's personal preferences for activities. D. On 05/14/25 at 9:26 AM, during an interview with the Activities Director, she confirmed R #4's Annual MDS assessment dated [DATE] is accurate and reflects the resident's personal preferences, and R #4's care plan does not include personal preferences from the Annual MDS Assessment. R #9 E. On 05/12/25 at 2:08 PM, during an interview, R #9 stated, I'm a Jehovah's witness so I can't participate in all the activities, but I do some. F. Record review of R #9's admission record (no date) revealed an admitted [DATE]. G. Record review of R #9's Activities Initial Review dated 09/17/24 revealed the following: 1. R #9 enjoys reading her spiritual books. 2. R #9 is a Jehovah Witness (Christian based religious movement known for their distinct beliefs and practices) 3. R #9 is looking forward to visit from her church group. H. Record review of R #9's Admission MDS assessment completed (signed by the RN/MDS Coordinator) on 10/01/24, revealed the following. 1. Section F - Preferences for Customary Routine and Activities. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	a. Question F0500, interview for activity preferences. How important is it to you to participate in religious services or practices? staff documented 1, very important I. Record review of R #9's care plan, initiated on 09/23/24, revealed staff did not document the following: 1. R #9's religion to include information on her distinct beliefs and practices. 2. Religious services and practices are very important to R #9. J. On 05/19/25 at 2:49 PM, during an interview, the MDS Coordinator confirmed the following: 1. Per documentation of the Activities Review and MDS Activities section R #9 did inform facility staff regarding the importance of her religion and religious practices. 2. R #9's care plan did not include her religion and religious preference or what specific activities R #9 could and could not participate in. 3. R #9's religious information should be included in her comprehensive care plan. 52223

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Mescalero Care Center	454 Lipan Avenue Mescalero, NM 88340

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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** 41755 Recite from 05/22/24 Based on record review and interview, the facility failed to ensure care plan revisions occurred for 4 (R #9, R #11, R #118, and R #130) of 6 (R #9, R #11, R #118, R #119, R #121, and R #130) residents when the staff failed to revise the care plan with the most current resident information. These deficient practices could likely result in the care plan not being updated with the most current resident conditions and appropriate interventions, staff being unaware of changes in care provided, and residents not receiving the care related to changes in their health status or healthcare decisions. The findings are: R #9 A. Record review of R #9's Admission Record (no date) revealed R #9 was admitted to the facility on [DATE]. B. Record review of R #9's CNA shower review forms dated 02/03/25 through 05/15/25 revealed the following: 1. R #9 was offered showers twenty-three times. 2. R #9 refused her showers eleven of the twenty-three times showers were offered to her. C. Record review of R #9's care plan dated 09/17/24 revealed the following: 1. R #9 requires partial/limited assistance with bathing/showering. 2. R #9's care plan was not revised to include residents refusal of showers and what actions staff could take to encourage her to shower. D. On 05/19/25 at 4:19 PM, during an interview, the MDS Coordinator confirmed that R #9's care plan was not revised to include her refusal of care (refusing to shower) and actions that staff could take to assist her to agree to shower. R #11 E. Record review of R #11's admission documents, no date, revealed the following: 1. R #11 was admitted to the facility on [DATE]. 2. R #11 had the following diagnoses: a. Lack of coordination. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	b. Muscle weakness. c. History of falling. F. Record review of R #16's progress note dated 04/16/25 revealed R #11 fell and was sent to the hospital. G. Record review of the facility's follow-up report, dated 04/18/24, revealed the facility implemented increased monitoring and redirection as interventions to prevent R #11 from falling again. H. Record review of R #11 care plan, revised 04/02/25, revealed staff did not revise R #11's care plan after she fell on [DATE]. I. On 05/19/25 at 2:31 PM, during an interview, the DON confirmed the following: 1. R #11 fell on [DATE]. 2. Close monitoring and redirection are interventions that are in place to prevent R #11 from falling. 3. R #11's care plan was not revised to include these interventions. 4. R #11's care plan should have been revised to include these interventions. R #118 J. Record review of R #118's admission documents, no date, revealed the following: 1. R #118 was admitted to the facility on [DATE]. 2. R #118 had the following diagnoses: a. History of falling. b. Dementia (term used to describe a group of symptoms affecting memory, thinking and social abilities). K. On 05/12/25 at 3:47 PM, during an interview with R #118's family member (FM) #1 the following was revealed: 1. R #118 fell approximately four weeks prior to the interview (FM #1 was unsure of the date). 2. R #118 tried to get out of bed on her own. 3. The facility placed a fall mat and R #118's bed in lowest position when she is in bed. 4. The provider ordered hydroxyzine to be added to R #118's medications to help with anxiety. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	L. Record review of R #118's physician's orders, multiple dates, revealed the following: 1. An order dated 03/15/25, for a fall mat and bed to be in lowest position when R #118 is in bed. 2. An order dated 04/03/25, for hydroxyzine 25 mg at bedtime for anxiety and restlessness. M. Record review of R #118's care plan, revised 03/24/25, revealed the following: 1. R #118's care plan was not revised to include a fall mat next to her bed or the bed to be in lowest position when she is in bed. 2. R #118's care plan was not revised to include R #118's order for hydroxyzine for anxiety or restlessness. N. On 05/14/25 at 10:27 AM, during an interview, the DON confirmed the following: 1. R #118's care plan was not revised to include a fall mat next to R #118's bed and the bed to be in lowest position when she was in bed. 2. She confirmed that resident care plans are expected to be revised with any interventions in place to prevent them from falling. R #130 O. Record review of R #130's Admission Record (no date) revealed R #130 was admitted to the facility on [DATE]. P. Record review of R #130's physician's orders revealed the following: 1. Alprazolam (generic for Xanax; medication primarily used to treat anxiety disorders and anxiety associated with depression) 0.25 mg, give 1 tablet by mouth three times daily for anxiety (mental health condition characterized by excessive fear, and worry that interfere with daily life) and restlessness (feelings of irritability, nervousness and mental distress). Start date 04/16/25. 2. Hydroxyzine tablet (prescription-only antihistamine [medication with sedating and calming effect] that is used to treat anxiety) 25 mg, give one tablet by mouth two times daily related to anxiety. Start date: 04/19/25. Q. Record review of R #130's care plan revised on 04/30/25 revealed the following: 1. R #130 uses anti-anxiety medications (Xanax) related to anxiety disorder. 2. R #130's care plan was not revised to include that R #130 also takes hydroxyzine for anxiety. R. On 05/19/25 at 2:20 PM, during an interview, the MDS Coordinator confirmed that R #130's care plan was not revised to include that R #130 also takes hydroxyzine for anxiety. 49313

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41755 Based on observation, record review, and interviews, the facility failed to meet professional standards of practice (established guidelines and expectations that ensure the delivery of high-quality care to residents) for 2 (R #1 and R #121) of 2 (R #1 and R #121) residents reviewed for unnecessary medication use and wound care when staff failed to: 1. Notify the physician about R #1's elevated blood pressure as indicated on physician's order. 2. Obtain wound care orders prior to performing wound care on R #121's right leg. If the facility is not providing care per physician's orders and care that meets professional standards of practice, then residents are likely to experience adverse effects, worsening of their condition, and potential complications from not receiving the care ordered by the physician. The findings are: R #1 A. Record review of R #1's admission record (no date) revealed the following: 1. R #1 was admitted to the facility on [DATE]. 2. R #1 had a diagnosis of essential (primary) hypertension (common form of high blood pressure that does not have a known secondary cause and is influenced by various lifestyle and genetic factors). B. Record review of R #1's physician orders revealed an order for Amlodipine (high blood pressure primarily used to treat high blood pressure and chest pain by relaxing blood vessels which lowers blood pressure and decreases the hears workload) tablet 10 mg, give 1 tablet by mouth in the morning for high blood pressure (HTN; hypertension medical term for high blood pressure) hold (do not give medication) and call doctor if systolic blood pressure (SBP, top number of blood pressure reading) is less than 100, diastolic blood pressure (DBP, bottom number of blood pressure reading) is less than 50 and/or pulse (heart rate, beats per minute) is less than 50. Administer (give medication) and call doctor if SBP is greater than 180, DBP is greater than 100 and/or Pulse is greater than 100. C. Record review of R #1's medication administration record (MAR; a form used to document medication administration), dated April 2025, revealed staff documented the following: 1. On 04/01/25 staff documented bp 195/63 and administered amlodipine. 2. On 04/05/25 staff documented bp 181/64 and administered amlodipine. 3. On 04/08/25 staff documented pulse 47 and administered amlodipine. 4. On 04/08/25 staff documented pulse 43 and administered amlodipine. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	5. On 04/09/25 staff documented bp 184/81 and administered amlodipine. 6. On 04/12/25 staff documented bp 189/78 and administered amlodipine. D. Record review of R #1's MAR dated May 2025, revealed staff documented the following: 1. On 05/04/25 staff documented bp 190/82 and administered amlodipine. 2. On 05/05/25 staff documented bp 198/74 and administered amlodipine. 3. On 05/06/25 staff documented bp 189/73 and administered amlodipine. 4. On 05/07/25 staff documented bp 185/76 and administered amlodipine. 5. On 05/10/25 staff documented bp 185/79 and administered amlodipine. 6. On 05/11/25 staff documented bp 217/92 and administered amlodipine. 7. On 05/13/25 staff documented bp 185/79 and administered amlodipine. 8. On 05/14/25 staff documented bp 182/70 and administered amlodipine. 9. On 05/15/25 staff documented bp 215/74 and administered amlodipine. E. Record review of R #1's progress notes for March and April 2025, revealed staff did not document that they notified the physician of R #1's elevated blood pressure (SBP higher than 180) or low pulse (heart rate less than 50). F. On 05/19/25 at 3:19 PM, during an interview, the DON confirmed the following: 1. R #1's blood pressure was elevated, and her pulse was low. 2. R #1's order indicates that staff are to call physician when blood pressure is greater than 180 and heart rate is less than 50. 3. Facility staff did not call the physician as indicated on the order and staff are expected to follow the physician's order. R #121 G. Record review of R #121's admission record (no date) revealed the following: 1. R #121 was admitted to the facility on [DATE]. 2. R # 121 had a diagnosis of cellulitis (a common and potentially serious bacterial skin infection) of unspecified toe. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	H. On 05/12/25 at 2:18 PM, during an interview and observation of R #121, the following was revealed: 1. R #121 stated she had cellulitis in both legs. 2. Her right leg was worse than her left leg. 3. She stated that the nurses were performing wound care on both of her legs. 4. She had bandages to both legs. 5. She stated she was on antibiotics for the cellulitis. 6. The provider ordered for her to see the wound care specialist, but she didn't know the date of the scheduled appointment. I. Record review of R #121's physician orders, multiple dates, revealed the following: 1. An order dated 04/16/25, for dry dressing and kerlix (bandage roll that provides absorbency and aeration) wrap to left lower leg blister every day and as needed until healed. 2. R #121's medical record did not have orders for wound care for R #121's right leg. J. Record review of R #121's TAR for May 2025 revealed the following: 1. dry dressing and kerlix wrap to left lower leg blister every day and as needed until healed. 2. Staff documented treatment was administered as ordered. K. On 05/15/25 at 12:27 PM, during an interview with RN #17, the following was revealed: 1. R #121 has wounds on both of her legs. 2. R #121's right leg wounds were worse than her left. 3. She performed wound care on both of R #121's legs. 4. For wound care, she washed R #121's wounds with wound care solution or normal saline (a mixture of water and salt with a salt concentration of .9%). Then put a non-adhesive (non-stick) dressing over the wounds and wrapped with kerlix. 5. She confirmed that R #121 had wound care orders for her left leg. 6. She confirmed that R #121 did not have orders for wound care to her right leg. 7. She stated that R #121's wounds on both legs were healing. 8. She confirmed R #121 had an appointment scheduled with the wound care specialist on 05/19/25. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	L. On 05/19/25 at 2:24 PM, during an interview, the DON confirmed the following: 1. R #121 had cellulitis in both legs. 2. Staff were performing wound care on both of R #121's legs. 3. R #121 did not have physician's orders for wound care for R #121's right leg. 4. Staff were expected to get orders for wound care for R #121's right leg prior to performing wound care on the right leg. 49313

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 52223 Based on record review and interview the facility failed to provide an ongoing activity program to support residents in their choice of activities designed to support their physical, mental, and psychosocial well-being for 1 (R #4) of 1 (R #4) resident reviewed for activities. If the facility does not ensure that all residents are receiving an ongoing activity program, documenting resident refusals, and making in-room activity accommodations, then residents are likely to demonstrate an increase in isolation and depression and could likely experience a decline in independence. The findings are: A. Record review of R #4's Admission record no date revealed an admitted [DATE]. B. Record review of R #4's Annual MDS assessment dated [DATE] revealed R #4's personal preferences for activities. C. Record review of R #4's care plan dated 09/30/24 revealed R #4's care plan did not include her personal preferences from the MDS Annual Assessment. D. Record review of R #4's Activity Individual Participation Record dated March 2025 revealed staff did not document that activities occurred for the following personal preferences: 1. Spiritual/religious activities. 2. Music. 3. Books, newspapers, and magazines to read. E. Record review of R #4's Activity Individual Participation Record dated April 2025 revealed staff did not document that activities occurred for the following personal preferences: 1. Spiritual/religious activities. 2. Music. 3. Books, newspapers, and magazines to read. F. Record review of R #4's Activity Individual Participation Record dated May 2025 revealed staff did not document that activities occurred for the following personal preferences: 1. Spiritual/religious activities. 2. Music. 3. Books, newspapers, and magazines to read. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	G. On 05/14/25 at 9:12 AM, during an interview, R #4 stated she was not offered activities in her room. R #4 stated no one comes in and watches tv with me, no talking or conversing. R #4 stated she would like a prayer, or bible study regarding Catholic religion, and likes all music, games, arts/crafts, gardening, any activity would be nice because she was not offered them by staff. H. On 05/14/25 at 9:26 AM, during an interview with the Activities Director, she confirmed the following: 1. R #4's Annual MDS assessment dated [DATE] is accurate and reflects resident's personal preferences for activities. 2. The Activities Director (AD) confirmed that she doesn't document everything for R #4 in the chart but is offering R #4 activities (contradicting R #4's statement). The AD will start documenting.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49313 Based on observation, interview, and record review, the facility failed to keep residents free from accidents for 1 (R #118) of 3 (R #11, R #118, and R #119) resident reviewed for accidents, when staff failed to ensure that ordered fall mats were in place when R #118 was in bed. This deficient practice could likely result in residents getting injured if they fall from their bed. The findings are: A. Record review of R #118's admission documents, no date, revealed the following: 1. R #118 was admitted to the facility on [DATE]. 2. R #118 had the following diagnoses: a. History of falling. b. Dementia (term used to describe a group of symptoms affecting memory, thinking and social abilities). B. On 05/12/25 at 3:47 PM during an interview with R #118's family member (FM) #1 the following was revealed: 1. R #118 fell approximately four weeks prior to the interview (FM #1 was unsure of the date). 2. R #118 tried to get out of bed on her own. 3. The facility placed a fall mat and R #118's bed in lowest position when she is in bed after the fall. C. Record review of R #118's physician's order, dated 03/15/25, for a fall mat and bed to be in lowest position when R #118 is in bed. D. On 05/12/25 at 2:15 PM during observation of R #118 in her room, revealed the following: 1. R #118 laid in her bed. 2. The bed was at the lowest position with the head elevated. 3. A fall mat was folded up next to R #118's bathroom. 4. A fall mat was not next to R #118's bed. E. On 05/13/25 at 2:25 PM during observation of R #118 in her room, revealed the following: 1. R #118 laid in her bed. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. The bed was at the lowest position with the head elevated. 3. A fall mat was folded up next to R #118's bathroom. 4. A fall mat was not next to R #118's bed. F. On 05/13/25 at 2:33 PM during an observation of R 118's room and interview with LPN #16, the following was confirmed: 1. She confirmed that R #118 was in bed and her fall mat was not next to the bed. 2. R #118's fall mat was supposed to be next to her bed when R #118 was in bed. G. On 05/13/25 at 2:35 PM during an interview, the DON confirmed the following: 1. R #118 had a history of falls. 2. R #118 had an order to have a fall mat next to her bed when she was in bed. 3. Staff were expected to put R #118's fall mat next to her bed when she was in bed.

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F 0712 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that the resident and his/her doctor meet face-to-face at all required visits. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41755 Recite from 05/22/24 Based on record review and interview, the facility failed to ensure that residents had a physician visit at least every 60 days for 4 (R #1, R #9, R #10, and R #118) of 5 (R #1, R #9, R #10, R #118, and R #130) residents reviewed for physician's visits. This deficient practice could likely result in residents not receiving the required medical assessment which could cause a delay in care and treatment of medical conditions. The findings are: R #1 A. Record review of R #1's Electronic Medical Record (EMR) revealed the following: 1. R #1 was admitted to the facility on [DATE]. 2. R #1 was seen by the Medical Director (clinician who oversees and guides the care provider to nursing home residents) on 12/29/24. 3. R #1 was seen by the Medical Director on 05/10/25. B. On 05/19/25 at 3:13 PM, during an interview, the DON confirmed that R #1 was not seen by the provider every 60 days. R #9 C. Record review of R #9's EMR revealed the following: 1. R #9 was admitted to the facility on [DATE]. 2. R #9 was seen by the Medical Director on 09/24/24. 3. R #9 was seen by the Medical Director on 05/02/25. D. On 05/19/25 at 3:44 PM during an interview, the DON confirmed that R #1 was not seen by the provider every 60 days. R #10 E. Record review of R #10's EMR revealed the following: 1. R #10 was admitted to the facility on [DATE]. 2. R #10 was seen at the local medical clinic on 07/24/24. 3. R #10 was seen by the Medical Director on 04/03/25. (continued on next page)

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F 0712 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	F. On 05/19/25 at 3:52 PM during an interview, the DON confirmed that R #10 was not seen by the provider every 60 days. R #118 G. Record review of R #118's EMR revealed the following: 1. R #118 was admitted to the facility on [DATE]. 2. Last physician visit was on 07/12/24. H. On 05/14/25 at 12:42 PM, during an interview, the DON stated the following: 1. The physician went to the facility weekly. 2. The physician saw all new residents during her weekly visits. 3. The physician saw all residents receiving skilled services weekly. 4. The physician saw any resident who had a specific need to be seen. 5. The physician saw all residents annually. 6. The DON confirmed that R #118 had not been seen by the physician since 07/12/24. 49313

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

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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 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observe each nurse aide's job performance and give regular training. 52223 Based on interview and record review, the facility failed to complete performance reviews at least every 12 months for 1 (CNA #26) of 2 (CNA #26 and CNA #28), CNAs sampled for 12 hours of annual training. This deficient practice could likely result in staff being undertrained and providing inadequate care. The findings are: A. Record review of CNA #26's employee files revealed the following: 1. CNA #26's hire date was 07/18/11. 2. CNA #26's last performance review was 02/20/24. B. On 05/19/25 at 2:48 PM during an interview, the Human Resource Manager confirmed that the last performance evaluation for CNA #26 was 02/20/24.

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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** 41755 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 (a set of reasons or a logical basis for a course of action or a particular belief) for not following the consultant pharmacist's recommendation in the residents' medical record for 4 (R #9, R #10, R #11 and R #118) of 7 (R #1, R #9, R #10, R #11, R #118, R #119, and R #130) residents reviewed for unnecessary medications. This deficient practice could likely result in residents receiving medications that are no longer necessary and may cause unnecessary drug interactions (changes to medication action caused by being combined with other foods, beverages, or drugs) or adverse side effects (unwanted, undesirable effects from medication). The findings are: R #9 A. Record review of R #9's admission record, no date, revealed the following: 1. R #9 was admitted to the facility on [DATE]. 2. R #9 had the following psychiatric diagnoses: a. Anxiety disorder (mental health condition characterized by excessive fear, worry, and anxiety that interfere with daily life). B. Record review of R #9's physician's orders revealed an order for sertraline tablet (antidepressant medication used to treat anxiety and depression disorders) give 50 mg by mouth one time a day for anxiety. Start date: 09/16/24. C. Record review of R #9's MAR, dated 05/01/25 through 05/19/25, revealed the following: 1. On 05/01/25, R #9 received sertraline 50 mg in the morning. 2. On 05/02/25, R #9 received sertraline 50 mg in the morning. 3. On 05/03/25, R #9 received sertraline 50 mg in the morning 4. On 05/04/25, R #9 received sertraline 50 mg in the morning. 5. On 05/05/25, R #9 received sertraline 50 mg in the morning. 6. On 05/06/25, R #9 received sertraline 50 mg in the morning. 7. On 05/07/25, R #9 received sertraline 50 mg in the morning. 8. On 05/08/25, R #9 received sertraline 50 mg in the morning. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	9. On 05/09/25, R #9 received sertraline 50 mg in the morning. 10. On 05/10/25, R #9 received sertraline 50 mg in the morning. 11. On 05/11/25, R #9 received sertraline 50 mg in the morning. 12. On 05/12/25, R #9 received sertraline 50 mg in the morning. 13. On 05/13/25, R #9 received sertraline 50 mg in the morning. 14. On 05/14/25, R #9 received sertraline 50 mg in the morning. 15. On 05/15/25, R #9 received sertraline 50 mg in the morning. 16. On 05/16/25, R #9 received sertraline 50 mg in the morning. 17. On 05/17/25, R #9 received sertraline 50 mg in the morning. 18. On 05/18/25, R #9 received sertraline 50 mg in the morning. 19. On 05/19/25, R #9 received sertraline 50 mg in the morning. D. Record review of R #9's Note to attending physician/prescriber (form that documents pharmacist recommendation regarding residents' medication(s) to the physician/prescriber dated 03/03/25 revealed the following: 1. R #9 has been taking the antidepressant sertraline 50 mg once daily for anxiety since 09/17/24. Please evaluate the current dose and consider a dose reduction (GDR). 2. The form had Resident with good response, maintain the current dose and Disagree marked. 3. The medical director (clinician who oversees and guides the care provider to nursing home residents) did not provide rationale with patient specific information as to why R #10 needed to remain on the medication. 4. The form was signed by the medical director and dated 03/23/25. E. On 05/19/25 at 3:50 PM, during an interview, the DON confirmed the following: 1. The pharmacist recommendation for R #9 was not implemented by the medical director. 2. The medical director did not provide a rationale for not performing a GDR for R #9's sertraline. R #10 F. Record review of R #10's admission record, no date, revealed the following: (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1. R #10 was admitted to the facility on [DATE]. 2. R #10 had the following psychiatric diagnoses: a. Depression (mood disorder that causes a persistent feeling of sadness and loss of interest). b. Restlessness and agitation (feelings of irritability, nervousness and mental distress). G. Record review of R #10's physician's orders, multiple dates, revealed the following: 1. Order dated 04/11/24 and discontinued 11/26/24, for sertraline tablet (antidepressant medication used to treat anxiety and depression disorders) 50 mg, give 1 tablet by mouth in the morning related to depression. 2. Order dated 11/27/24, for sertraline tablet 50 mg, give 1 tablet by mouth in the morning for depression as evidenced by sadness. 3. Order dated 04/08/24 and discontinued 11/26/24, for trazodone tablet give 50 mg by mouth at bedtime for insomnia (common sleep disorder that makes it hard to fall asleep or stay asleep). 4. Order dated 11/27/24, for trazodone tablet give 50 mg by mouth at bedtime for insomnia. 5. Order dated 06/09/24 and discontinued 11/26/24, for escitalopram tablet (antidepressant medication used to treat anxiety and depression disorders) 10 mg, give 2 tablets by mouth in the morning for depression. 6. Order dated 11/27/24, for escitalopram tablet 10 mg, give 2 tablets by mouth in the morning for depression as evidenced by social isolation. 7. Order dated 04/22/24 and discontinued 11/26/24, hydroxyzine tablet (prescription-only antihistamine [medication with sedating and calming effect] that is used to treat anxiety) 10 mg, give 1 tablet by mouth two times a day for anxiety related to restlessness and agitation. 8. Order dated 11/27/24, hydroxyzine tablet 10 mg, give 1 tablet by mouth two times a day for anxiety as evidenced by restlessness and agitation. H. Record review of R #10's MAR, dated 05/01/25 through 05/19/25, revealed the following: Sertraline 1. On 05/01/25, R #10 received sertraline 50 mg in the morning. 2. On 05/02/25, R #10 received sertraline 50 mg in the morning. 3. On 05/03/25, R #10 received sertraline 50 mg in the morning 4. On 05/04/25, R #10 received sertraline 50 mg in the morning. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	5. On 05/05/25, R #10 received sertraline 50 mg in the morning. 6. On 05/06/25, R #10 received sertraline 50 mg in the morning. 7. On 05/07/25, R #10 received sertraline 50 mg in the morning. 8. On 05/08/25, R #10 received sertraline 50 mg in the morning. 9. On 05/09/25, R #10 received sertraline 50 mg in the morning. 10. On 05/10/25, R #10 received sertraline 50 mg in the morning. 11. On 05/11/25, R #10 received sertraline 50 mg in the morning. 12. On 05/12/25, R #10 received sertraline 50 mg in the morning. 13. On 05/13/25 R #10 received sertraline 50 mg in the morning. 14. On 05/14/25, R #10 received sertraline 50 mg in the morning. 15. On 05/15/25, R #10 received sertraline 50 mg in the morning. 16. On 05/16/25, R #10 received sertraline 50 mg in the morning. 17. On 05/17/25, R #10 received sertraline 50 mg in the morning. 18. On 05/18/25, R #10 received sertraline 50 mg in the morning. 19. On 05/19/25, R #10 received sertraline 50 mg in the morning. Trazodone 20. On 05/01/25, R #10 received trazodone 50 mg in the evening. 21. On 05/02/25, R #10 received trazodone 50 mg in the evening. 22. On 05/03/25, R #10 received trazodone 50 mg in the evening. 23. On 05/04/25, R #10 received trazodone 50 mg in the evening. 24. On 05/04/25, R #10 received trazodone 50 mg in the evening. 25. On 05/06/25, R #10 received trazodone 50 mg in the evening. 26. On 05/07/25, R #10 received trazodone 50 mg in the evening. 27. On 05/08/25, R #10 received trazodone 50 mg in the evening. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	28. On 05/09/25, R #10 received trazodone 50 mg in the evening. 29. On 05/10/25, R #10 received trazodone 50 mg in the evening. . 30. On 05/11/25, R #10 received trazodone 50 mg in the evening. 31. On 05/12/25 R #10 received trazodone 50 mg in the evening. 32. On 05/13/25, R #10 received trazodone 50 mg in the evening. 33. On 05/14/25, R #10 received trazodone 50 mg in the evening. 34. On 05/15/25, R #10 received trazodone 50 mg in the evening. 35. On 05/16/25, R #10 received trazodone 50 mg in the evening. 36. On 05/17/25, R #10 received trazodone 50 mg in the evening. 37. On 05/18/25, R #10 received trazodone 50 mg in the evening. Escitalopram 38. On 05/01/25, R #10 received escitalopram 20 mg in the morning. 39. On 05/02/25, R #10 received escitalopram 20 mg in the morning. 40. On 05/03/25, R #10 received escitalopram 20 mg in the morning. 41. On 05/04/25, R #10 received escitalopram 20 mg in the morning. 42. On 05/05/25, R #10 received escitalopram 20 mg in the morning. 43. On 05/06/25, R #10 received escitalopram 20 mg in the morning. 44. On 05/07/25, R #10 received escitalopram 20 mg in the morning. 45. On 05/08/25, R #10 received escitalopram 20 mg in the morning. 46. On 05/09/25, R #10 received escitalopram 20 mg in the morning. 47. On 05/10/25, R #10 received escitalopram 20 mg in the morning. 48. On 05/11/25, R #10 received escitalopram 20 mg in the morning. 49. On 05/12/25, R #10 received escitalopram 20 mg in the morning. 50. On 05/13/25 R #10 received escitalopram 20 mg in the morning. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	51. On 05/14/25, R #10 received escitalopram 20 mg in the morning. 52. On 05/15/25, R #10 received escitalopram 20 mg in the morning. 53. On 05/16/25, R #10 received escitalopram 20 mg in the morning. 54. On 05/17/25, R #10 received escitalopram 20 mg in the morning. 55. On 05/18/25, R #10 received escitalopram 20 mg in the morning. 56. On 05/19/25, R #10 received escitalopram 20 mg in the morning. Hydroxyzine 57. On 05/01/25, R #10 received hydroxyzine 10 mg twice daily. 58. On 05/02/25, R #10 received hydroxyzine 10 mg twice daily. 59. On 05/03/25, R #10 received hydroxyzine 10 mg twice daily. 60. On 05/04/25, R #10 received hydroxyzine 10 mg twice daily. 61. On 05/05/25, R #10 received hydroxyzine 10 mg twice daily. 62. On 05/06/25, R #10 received hydroxyzine 10 mg twice daily. 63. On 05/07/25, R #10 received hydroxyzine 10 mg twice daily. 64. On 05/08/25, R #10 received hydroxyzine 10 mg twice daily. 65. On 05/09/25, R #10 received hydroxyzine 10 mg twice daily. 66. On 05/10/25, R #10 received hydroxyzine 10 mg twice daily. 67. On 05/11/25, R #10 received hydroxyzine 10 mg twice daily. 68. On 05/12/25, R #10 received hydroxyzine 10 mg twice daily. 69. On 05/13/25, R #10 received hydroxyzine 10 mg twice daily. 70. On 05/14/25, R #10 received hydroxyzine 10 mg twice daily. 71. On 05/15/25, R #10 received hydroxyzine 10 mg twice daily. 72. On 05/16/25, R #10 received hydroxyzine 10 mg twice daily. 73. On 05/17/25, R #10 received hydroxyzine 10 mg twice daily. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	74. On 05/18/25, R #10 received hydroxyzine 10 mg twice daily. I. Record review of R #10's Recommendation Summary for DON and medical director (pharmacist recommendation to the DON and medical director regarding residents' medications) dated 02/03/25, revealed the following: 1. R #10 has a history of chronic depression and has been receiving the current dose sertraline 50 mg every morning since 04/11/24, trazodone 50 mg at bedtime since 04/08/24, and escitalopram 20 mg every morning since 06/09/24 2. Federal guidelines require assessment of medication therapy showing benefit to risk for continuing therapy and periodic dose reduction trials when medications may no longer be necessary. Please check the appropriate response and add additional information as requested. 3. The form had Patient has had good response to treatment and requires this dose for condition stability. Dose reduction is contraindicated because benefits outweigh risks for this patient at this time and a reduction is likely to impair the residents function and or cause psychiatric instability. (Please elaborate with patient specific information marked. 4. The medical director did not provide rationale with patient specific information as to why R #10 needed to remain on the medications. 5. The form was signed by the medial director and dated 03/23/25. J. Record review of R #10's Note to attending physician (form that documents pharmacist recommendation regarding residents' medication(s) to the physician/prescriber dated 04/01/25, revealed the following: 1. R #10 has been taking the anxiolytic (class of medications used to prevent or treat anxiety symptoms or disorders) hydroxyzine 10 mg twice daily for anxiety since 04/22/24. Please evaluate the current dose and consider a dose reduction. 2. The form had Resident with good response, maintain the current dose marked. 3. The medical director did not provide rationale with patient specific information as to why R #10 needed to remain on the same dose of hydroxyzine. 4. The form was signed by the medical director and dated 04/03/25. K. On 05/19/25 at 3:57 PM, during an interview, the DON confirmed the following: 1. The pharmacist recommendation for R #10 was not implemented by the medical director. 2. The medical director did not provide a rationale for not performing GDR's for R #10's medications. 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	L. 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 psychiatric diagnoses: a. Major Depressive Disorder (MDD, mental health disorder characterized by persistently depressed mood or loss of interest in activities, causing significant impairment in daily life) b. Panic disorder [Episodic Paroxysmal Anxiety] (mental and behavioral disorder, specifically an anxiety disorder characterized by recurring unexpected panic attacks). c. Psychotic Disorder with Hallucinations due to known physiological condition (a condition when people lose some contact with reality. This might involve seeing or hearing things that other people cannot see or hear (hallucinations) and believing things that are not actually true (delusions)). d. Insomnia (a common sleep disorder that can make it hard to fall asleep or stay asleep). M. Record review of R #11's physician's orders, multiple dates, revealed the following: 1. Order dated 04/29/24, and discontinued 11/26/24, for buspirone (medication that can treat anxiety) 5 mg tablet, one tablet twice a day for anxiety. 2. Order dated 11/26/24, for buspirone 5 mg tablet, one tablet twice a day for anxiety. 3. Order dated 09/29/23 and discontinued 11/26/24, for lorazepam 0.5 mg tablet, one tablet twice a day for anxiety. 4. Order dated 11/26/24, for lorazepam (medication that can treat anxiety) 0.5 mg tablet, one tablet twice a day for anxiety. 5. Order dated 07/07/23 and discontinued 10/01/23, for trazadone 50 mg, one tablet in the evening for insomnia. 6. Order dated 10/01/23 and discontinued 11/26/24, for trazadone 50 mg, one tablet in the evening for depression, MDD, insomnia. 7. Order dated 11/26/24, for trazadone 50 mg tablet, one tablet in the evening for depression, MDD, insomnia. 8. Order dated 08/03/23 and discontinued 11/26/24, for mirtazapine 7.5 mg, give 1/2 of 15 mg tablet in the evening for depression. 9. Order dated 11/26/24, for mirtazapine 7.5 mg, give 1/2 of 15 mg tablet in the evening for depression. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	10. Order dated 06/30/23, for Nuplazid 34 mg, give one capsule at bedtime for hallucinations related to Parkinson's disease, psychotic disorder with hallucinations due to known physiological condition. N. Record review of R #11's MAR, dated May 2025, revealed the following: 1. R #11 received Lorazepam 0.5 mg twice a day as ordered. 2. R #11 received buspirone 5 mg twice a day as ordered. 3. R #11 received trazadone 50 mg in the evening as ordered. 4. R #11 received mirtazapine 7.5 mg in the evening as ordered. 5. R #11 received Nuplazid 34 mg in the evening as ordered. O. Record review of the Psychotropic & Sedative/Hypnotic Utilization By Resident report (pharmacist spreadsheet that includes information about the use of psychotropic, sedative, and hypnotic medications), dated 05/02/25, revealed the following: 1. R #11 had an order for buspirone 5 mg twice a day since 04/29/24, and a GDR was declined in February 2025. 2. R #11 had an order for lorazepam 0.5 mg twice a day since 09/29/23, and a GDR was declined in September 2024. 3. R #11 had an order for mirtazapine (antidepressant medication) 7.5 mg in the evening for depression since 08/03/23, and a GDR was declined in September 2024. 4. R #11 had an order for Nuplazid 34 mg at bedtime since 06/30/23, and a GDR was recommended in April 2025. 5. R #11 had an order for trazadone 50 mg at bedtime since 10/01/23, and a GDR was declined in October 2024. P. Record review of R #11's pharmacist recommendation, dated 08/03/24, revealed the following: 1. R #11 has a history of chronic depression and has been receiving the current dose of mirtazapine 7.5 mg in the evening for depression since 08/03/23. Federal guidelines require assessment of medication therapy showing benefit to risk for continuing therapy and periodic dose reduction trials when medications may no longer be necessary. Please check the appropriate response and add additional information as requested: 2. The form had Patient has had a good response to treatment and requires this dose for condition stability. Dose reduction is contraindicated because benefits outweigh risks for this patient at this time and a reduction is likely to impair the resident's function and/or cause psychiatric instability. (Please elaborate with patient specific information) selected. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. The form had agree selected with a provider signature and date of 09/15/24. 4. R #11's physician did not provide rationale with patient specific information as to why resident needed to remain on medication. Q. Record review of R #11's pharmacist recommendation, dated 09/03/24, revealed the following: 1. R #11 has been taking the anxiolytic lorazepam 0.5 mg twice daily since 09/28/23. Please evaluate the current dose and consider a dose reduction. 2. The form had agree selected with a signature and date of 09/09/24. 3. The form had a note dated 09/16/24, verbal order to continue med. Per order by [Doctor Name]. 4. R #11's physician did not provide rationale with patient specific information as to why resident needed to remain on medication. R. Record review of R #11's pharmacist recommendation, dated 10/04/24, revealed the following: 1. R #11 has a history of chronic depression and has been receiving the current dose of trazadone 50 mg at bedtime for depression since 10/01/23. Federal guidelines require assessment of medication therapy showing benefit to risk for continuing therapy and periodic dose reduction trials when medications may no longer be necessary. Please check the appropriate response and add additional information as requested: 2. The form had Patient has had a good response to treatment and requires this dose for condition stability. Dose reduction is contraindicated because benefits outweigh risks for this patient at this time and a reduction is likely to impair the resident's function and/or cause psychiatric instability. (Please elaborate with patient specific information) selected. 3. R #11's physician did not provide rationale with patient specific information as to why resident needed to remain on medication. 4. The form had a note, dated 10/14/24, [Name of nurse practitioner] verbal continue of this dose. S. Record review of R #11's pharmacist recommendation, dated 02/03/25, revealed the following: 1. R #11 has been taking the anxiolytic buspirone 5 mg since 04/29/24. Please evaluate the current dose and consider a dose reduction (GDR). 2. The form had Condition stable: Attempt dose reduction to discontinue this medication, Resident with good response, maintain the current dose, and Disagree marked. 3. R #11's physician did not provide rationale with patient specific information as to why resident needed to remain on medication. 4. The form had a comment dated 02/19/25, MD intended to keep resident on current dose, verified by [DON signature]. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	T. Record review of R #11's pharmacist recommendation, dated 04/05/25, revealed the following: 1. R #11 has been taking the antipsychotic Nuplazid 34 mg at bedtime for psychotic disorder with hallucinations related to Parkinson's Disease since 06/30/23. Please evaluate the current dose and consider a dose reduction. 2. The form had Resident with good response, maintain the current dose. 3. The form had agree selected with a signature and date of 05/09/25. 4. R #11's physician did not provide rationale with patient specific information as to why resident needed to remain on medication. U. On 05/19/25 at 2:34 PM, during an interview, the DON confirmed the following: 1. R #11 has not had a GDR for buspirone, lorazepam, mirtazapine, trazadone, or Nuplazid. 2. The provider did not provide a rationale for why she did not perform a GDR for R #11 for buspirone, lorazepam, mirtazapine, trazadone, or Nuplazid. R #118 V. Record review of R #118's physician's orders, multiple dates, revealed the following: 1. An order, dated 07/15/24 and discontinued on 05/13/25, for Mirtazapine 7.5 mg in the evening for appetite and depression. 2. An order, dated 05/13/25, for Mirtazapine 7.5 mg in the evening for appetite and depression. W. Record review of R #118's MAR, dated 05/01/25 to 05/12/25, revealed the following: 1. On 05/01/25, R #118 received mirtazapine 7.5 mg in the evening. 2. On 05/02/25, R #118 received mirtazapine 7.5 mg in the evening. 3. On 05/03/25, R #118 refused mirtazapine 7.5 mg in the evening. 4. On 05/04/25, R #118 refused mirtazapine 7.5 mg in the evening. 5. On 05/05/25, R #118 received mirtazapine 7.5 mg in the evening. 6. On 05/06/25, R #118 received mirtazapine 7.5 mg in the evening. 7. On 05/07/25, R #118 received mirtazapine 7.5 mg in the evening. 8. On 05/08/25, R #118 received mirtazapine 7.5 mg in the evening. 9. On 05/09/25, R #118 received mirtazapine 7.5 mg in the evening. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	10. On 05/10/25, R #118 received mirtazapine 7.5 mg in the evening. 11. On 05/11/25, R #118 received mirtazapine 7.5 mg in the evening. 12. On 05/12/25, R #118 refused mirtazapine 7.5 mg in the evening. X. Record review R #118's pharmacist recommendation, dated 05/02/25, revealed the following: 1. R #118 has a history of chronic depression and has been receiving the current dose of mirtazapine 7.5 mg in the evening for depression since 07/15/24. Federal guidelines require assessment of medication therapy showing benefit to risk for continuing therapy and periodic dose reduction trials when medications may no longer be necessary. Please check the appropriate response and add additional information as requested: 2. The form had Patient has had a good response to treatment and requires this dose for condition stability. Dose reduction is contraindicated because benefits outweigh risks for this patient at this time and a reduction is likely to impair the resident's function and/or cause psychiatric instability. (Please elaborate with patient specific information) selected. 3. The form a provider signature and date of 05/09/25. 4. R #11's physician did not provide rationale with patient specific information as to why resident needed to remain on medication. Y. On 05/19/25 at 2:16 PM, during an interview, the DON confirmed the following: 1. R #118 has not had a GDR for mirtazapine. 2. The provider did not provide a rationale for why she did not perform a GDR for R #118 for mirtazapine. 49313

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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 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide or obtain dental services for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41755 Recite from 05/22/24 Based on record review and interview the facility failed to ensure residents obtained dental services for 3 (R #9, R #10 and R #123) of 4 (R #9, R #10, R #121 and R #123) residents sampled for dental services, when staff failed to ensure residents receive routine dental care to include an annual inspection of the mouth for signs of disease, dental cleaning, fillings, or minor partial or full denture adjustments. This deficient practice is likely to cause the resident unnecessary pain, embarrassment over the condition/appearance of teeth, and potential dental or oral complications. The findings are: R #9 A. On 05/12/25 at 2:15 PM, during an interview, R #9 stated that she needed to have her dentures checked because they were loose. B. Record review of R #9's Admission Record, no date, revealed an admitted [DATE]. C. Record review of R #9's physician's order dated 09/16/24 revealed Dental consult as needed. D. On 05/15/25 at 1:58 PM, during an interview with Medical Records staff, she confirmed R #9 had not been seen by a dentist since her admission. R #10 E. On 05/13/25 at 10:22 AM, during an interview, R #10's Power of Attorney (POA; legal document that appoints someone as a representative and allows them to act on one's behalf) stated that R #10 had a dental filling that fell out approximately 6 months ago. R #10's POA stated she asked for the facility to schedule an appointment, but she is unsure if she was seen by a dentist. F. Record review of R #10's physician's order dated 05/20/24 revealed Dental consult as needed. G. Record review of R #10's Weekly Oral/Dental Assessment, dated 11/29/24 revealed Upper gums red, irritated. Currently using medicated mouthwash for treatment. Resident broke her silver cap off a tooth yesterday 11/28/24. Transportation noted to make resident dentist appointment. Passed on in nursing report and nursing staff. H. Record review of R #10's progress notes revealed Social Service Note dated 12/13/24 at 1:57 PM: POA reported that her filling fell out of her mouth, she did report it to nurse. POA request that she needs to be taken to a dentist. I. On 05/15/25 at 1:58 PM, during an interview with Medical Records staff, she confirmed R #10 had not been seen by a dentist after 11/28/24. R #123 (continued on next page)

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	J. Record review of R #123's face sheet, no date, revealed an admitted [DATE]. K. On 05/13/25 at 2:23 PM, during an interview, R #123 stated he had toothache, and he has not been to the dentist since his admission to the facility. L. Record review of R #123's treatment administration record dated 05/01/25 revealed dental consultation as needed. M. On 05/14/25 11:19 AM during an interview, DON stated she did not know that R #123 had a tooth ache. DON confirmed that R #123 did not have a monthly dental assessment in his record, and R #123 has been at the facility since 05/06/25 and has not seen a dentist in this time. 52223

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F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician. 49313 Based on an interviews the facility failed to employ a Certified Dietary Manager (CDM) that met the requirements as follows: (A) A certified dietary manager; or (B) A certified food service manager; or (C) Had similar national certification for food service management and safety from a national certifying body; or (D) Had an associate's or higher degree in food service management or in hospitality, if the course study includes food service or restaurant management, from an accredited institution of higher learning; or (E) Had two or more years of experience in the position of director of food and nutrition services in a nursing facility setting and has completed a course of study in food safety and management, by no later than October 1, 2023, that included topics integral to managing dietary operations including, but not limited to, foodborne illness, sanitation procedures, and food purchasing/receiving. This failure could potentially affect all 29 residents in the facility who eat food prepared in the kitchen (residents were identified by the Resident Matrix provided by the Administrator on 05/12/25). If the facility fails to employ qualified dietary staff, residents nutritional needs may not be met and they could likely suffer adverse outcomes. The findings are: A. On 05/12/25 at 1:36 PM, during an interview, Dietary Staff #16 revealed that the facility did not have a dietary manager (DM). B. On 05/12/25 at 1:38 PM, during an interview, [NAME] #16 revealed the following: 1. The facility did not have a DM. 2. They had not had a DM for approximately a month. 3. He was not sure if the facility had a dietitian. C. On 05/15/25 at 12:17 PM, during an interview, the Administrator confirmed the following: 1. The dietitian works at the facility one day a week. 2. The facility had not had a DM since 04/18/25. 3. The facility hired a DM that was expected to start on 05/23/25.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49313 Recite from [DATE] Based on observation and interview, the facility failed to store and serve food under sanitary conditions in accordance with professional standards of food service safety for all 29 residents in the facility (residents were identified by resident matrix provided by the Administrator on [DATE]) who eat food or drinks stored in the nutrition refrigerator or freezer when staff failed to: 1. Maintain refrigerator temperatures in the nutrition refrigerators (refrigerator near the nursing station that contains drinks and snacks for residents). 2. Food stored in the nutrition refrigerator was not expired. 3. Food stored in the nutrition refrigerator or freezer had an expiration date. 4. Food that was supposed to be frozen was not thawed in the refrigerator. If the facility fails to adhere to safe food storage, residents could likely be exposed to foodborne illnesses (illness caused by food contaminated with bacteria, viruses, parasites, or toxins). The findings are: A. On [DATE] at 11:53 AM, during an observation of the nourishment room refrigerator revealed there was no temperature log for the refrigerator or freezer. B. On [DATE] at 11:54 AM, during an interview, RN #16 stated that the kitchen staff take the temperatures in the nourishment room refrigerator. C. On [DATE] at 12:05 PM, during an interview, Dietary Aide (DA) #16 stated she was unsure where the nourishment room temperature log was. D. On [DATE] at 12:21 PM, during an observation of the nutrition refrigerator and freezer revealed the following: 1. A sandwich was in the refrigerator with a date written on it of [DATE]. 2. A bag of shredded cheese in the refrigerator with an expiration date of [DATE]. 3. Several individually packaged peanut butter and jelly sandwiches in the refrigerator with no date and no expiration date. The wrappers stated thaw and serve (should be stored in the freezer until ready to serve). E. On [DATE] at 12:24 PM, during an interview, the DON confirmed the following: 1. The sandwich in the nutrition room refrigerator was expired. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	2. The cheese in the nutrition room refrigerator was expired. 3. The individually packaged peanut butter and jelly sandwiches did not have a date that they would expire. 4. The individually packaged peanut butter and jelly sandwiches should have had a date that they expired written on them and should have been stored in the freezer and not the refrigerator. 5. There was no refrigerator or freezer temperature log in the nutrition room. 6. She was unsure if anyone had been checking the temperature of the nutrition room refrigerator or freezer. 7. Kitchen staff were responsible for the following in the nourishment room: a. Taking temperatures of the refrigerator and freezer. b. Stocking refrigerator and freezer and other snacks in the room. c. Removing expired items. F. On [DATE] at 12:38 PM, during an interview, DA #16 confirmed the kitchen staff had not been checking temperatures for the nutrition room refrigerator and freezer. She was unable to determine the last time the nutrition room refrigerator and freezer temperatures had been checked.

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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 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** 41755 Recite from 05/22/24 Based on record review and interview, the facility failed to ensure medical records were complete and accurate for 2 (R #9 and R #118) of 6 (R #1, R #9, R #10, R #118, R #130 and R #131) residents reviewed for documentation accuracy. This deficient practice has the potential to negatively impact on the care staff provide to meet residents' needs due to missing or inaccurate records and resident information. The findings are: R #9 A. Record review of R #9's physician orders revealed the following: 1. An order dated 11/25/24 for acetaminophen (Tylenol; analgesic medication used to treat mild to moderate pain) tablet 325 mg, give 2 tablets by mouth every 4 hours as needed for pain. B. Record review of R #9's medication administration record (MAR; a form used to document medication administration), dated April 2025, revealed staff documented the following: 1. On 04/06/25 at 3:01 AM, staff documented acetaminophen was given for a pain level of 5 (pain scale 1-10, 10 highest). 2. On 04/08/25 at 1:30 PM, staff documented acetaminophen was given for a pain level of 4. 3. On 04/16/25 at 11:15 PM, staff documented acetaminophen was given for a pain level of 4. 4. On 04/30/25 at 4:25 AM, staff documented acetaminophen was given for a pain level of 6. C. Record review of R #9's MAR dated May 2025, revealed staff documented the following: 1. On 05/09/25 at 4:54 AM, staff documented acetaminophen was given for a pain level of 6. 2. On 05/09/25 at 9:46 PM, staff documented acetaminophen was given for a pain level of 5. 3. On 05/13/25 at 2:45 AM, staff documented acetaminophen was given for a pain level of 3. 4. On 05/14/25 at 3:00 AM, staff documented acetaminophen was given for a pain level of 5. 5. On 05/16/25 at 5:46 AM, staff documented acetaminophen was given for a pain level of 5. 6. On 05/17/25 at 5:45 AM, staff documented acetaminophen was given for a pain level of 5. 7. On 05/17/25 at 5:08 PM, staff documented acetaminophen was given for a pain level of 5. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	8. On 05/18/25 at 3:33 AM, staff documented acetaminophen was given for a pain level of 5. D. Record review of R #9's progress notes dated April 2025 and May 2025 revealed the following: 1. On 04/08/25 staff documented acetaminophen was given for throat pain. 2. Staff did not document the reason acetaminophen was given for any other dates in April or May. E. On 05/19/25 at 3:47 PM, during an interview with the DON, she confirmed the following: 1. Facility staff did not document the reason R #9 was given acetaminophen. 2. Facility staff did not document whether the acetaminophen was effective in treating R #9's complaints of pain. 3. She expects staff to document the location of the pain and whether the pain medication helped relieve the pain. 4. Documenting the pain location and effectiveness helps the facility staff and physician know if there needs to be additional treatment for complaints of pain or if medication changes are necessary. R #118 F. Record review of R #118's admission record, no date, revealed the following: 1. R #118 was admitted to the facility on [DATE]. 2. R #118 did not have any mental health diagnoses. G. Record review of R #118's physician's orders, multiple dates, revealed the following: 1. An order dated 07/15/24 and discontinued on 05/13/25, for Mirtazapine (antidepressant to treat major depressive disorder) 7.5 mg in the evening for appetite and depression. 2. An order dated 05/13/25, for Mirtazapine 7.5 mg in the evening for appetite and depression. H. Record review of R #118's provider's progress note, dated 07/12/24, revealed R #118 had a diagnosis of major depressive disorder (MDD, mood disorder that causes a persistent feeling of sadness and loss of interest). I. Record review of R #118's medical record, no date, revealed staff did not update R #118's medical diagnoses to include her diagnosis of MDD. J. On 05/19/25 at 2:16 PM, during an interview, the DON confirmed the following: 1. R #118's did not have a diagnosis of depression in her list of diagnoses in the medical record. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. R #118's provider progress note, dated 07/12/24, listed MDD as one of R #118's diagnoses. 3. Staff did not update R #118's electronic medical record (EMR) with the diagnosis of MDD. 4. Staff were expected to update resident EMR's with all new diagnoses 49313

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F 0941 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop, implement, and/or maintain an effective training program that includes effective communications for direct care staff members. 52223 Based on record review and interview, the facility failed to ensure that nursing staff have completed the mandatory Effective Communication training for 3 (RN #24, LPN #25, CNA #26) of 5 (RN #24, LPN #25, CNA #26, RN #27 and CNA # 28) staff randomly sampled for staffing. This deficient practice could likely result in staff being unable to inform residents of their total health status and to provide notice of rights and services. The findings are: A. Record review of RN #24's Online Training Transcript, no date revealed effective communication training was not completed. B. Record review of LPN #25's Online Training Transcript, no date revealed effective communication training was not completed. C. Record review of CNA #26's Online Training Transcript, no date revealed effective communication training was not completed. D. On 05/19/25 at 2:48 PM, during an interview, the Human Resource Manager confirmed that Effective Communication Training has not been completed for RN #24, LPN #25, and CNA #26.

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F 0942 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that staff members are educated on resident rights and facility responsibilities to properly care for its residents. 52223 Based on record review and interview, the facility failed to provide resident rights training (training that helps staff promote and protect the rights of each resident and places a strong emphasis on individual dignity and self-determination) for 4 staff (RN #24, LPN #25, CNA #26, and RN #27) of 5 (RN #24, LPN #25, CNA #26, RN #27 and CNA # 28) staff sampled for training. This deficient practice could likely result in staff being unaware of residents rights resulting in negative psychosocial well-being for residents. The findings are: A. Record review of staff training records revealed RN #24 did not complete training for resident rights. B. Record review of staff training records revealed LPN #25 did not complete training for resident rights. C. Record review of staff training records revealed CNA #26 did not complete training for resident rights. D. Record review of staff training records revealed RN #27 did not complete training for resident rights. E. On 05/19/25 at 2:48 PM, during an interview, the Human Resource Manager confirmed that RN #24, LPN #25, CNA #26, and RN #27 did not complete the training.

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F 0943 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give their staff education on dementia care, and what abuse, neglect, and exploitation are; and how to report abuse, neglect, and exploitation. 52223 Based on record review and interview, the facility failed to provide abuse, neglect, and exploitation training to 1 staff (RN #24) of 5 (RN #24, LPN #25, CNA #26, RN #27 and CNA #28) staff sampled for training. This deficient practice could likely result in staff not knowing who, what, and when to report abuse, neglect, and exploitation. The findings are: A. Record review of RN #24's training transcript, no date, revealed that abuse, neglect, and exploitation training was last completed 12/31/23. B. On 05/19/25 at 2:48 PM, during an interview, the Human Resource Manager (HRM) confirmed that RN #24 did not complete the required training since 2023. The HRM confirmed that the training should be completed annually.

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F 0944 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Conduct mandatory training, for all staff, on the facility's Quality Assurance and Performance Improvement Program. 52223 Based on record review and interview, the facility failed to ensure that nursing staff have completed the mandatory QAPI (Quality Assurance/Performance Improvement) training for 3 (RN #24, LPN #25, CNA #26) of 5 (RN #24, LPN #25, CNA #26, RN #27 and CNA #28) staff randomly sampled for staffing. This deficient practice could likely result in staff being unable to identify opportunities for improvement, address gaps in systems or processes, develop and implement an improvement or corrective plan, and continuously monitor the effectiveness of interventions. The findings are: A. Record review of the employee training transcript, no date, revealed RN #24 did not complete QAPI training. B. Record review of the employee training transcript, no date, revealed LPN #25 did not complete QAPI training. C. Record review of the employee training transcript, no date, revealed CNA #26 did not complete QAPI training. D. On 05/19/25 2:48 PM, during an interview, the Human Resource Manager confirmed that the QAPI training has not been completed for RN #24, LPN #25, and CNA #26.

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F 0945 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Include as part of its infection prevention and control program, mandatory training that includes written standards, policies, and procedures for the program. 52223 Based on record review and interview, the facility failed to provide infection control training (training that helps staff recognize various infection control prevention to help stop the spread of infections) for 2 (RN #24 and CNA #26) of 5 (RN #24, LPN #25, CNA #26, RN #27 and CNA #28) staff sampled for training. This deficient practice could likely result in inadequate infection control, and can lead to increased spread of resistant organisms, and risk of infections among residents and staff. The findings are: A. Record review of staff training records revealed CNA #26 completed training for infection control on 11/11/22. B. Record review of staff training records revealed RN #24 completed training for infection control on 12/31/23. B. On 05/19/25 at 2:48 PM, during an interview, the Human Resource Manager (HRM) confirmed that CNA #26 and RN #24 did not complete the training for the year 2025. The HRM confirmed that the training should be completed annually.

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	05/19/2025

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 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. 52223 Based on record review and interview, the facility failed to ensure that each CNA received a minimum of 12 in-service hours a year based on hire date for 1 (CNA #26) of 2 (CNA #26, and CNA #28) CNAs sampled for training. If CNAs are not adequately trained, they are unable to provide the necessary care and services to residents. The findings are: A. Record review of the facility's CNA training records revealed the following: 1. CNA #26 hire date was 07/18/11. 2. CNA #26 had 1 training in-service hour taken on 11/22/24. B. On 05/19/25 at 2:48 PM, during an interview, the Human Resource Manager confirmed that CNA #26 did not have the minimum of 12 in-service hours a year.

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	05/19/2025

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

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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 0949 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide behavior health training consistent with the requirements and as determined by a facility assessment. 52223 Recite from 05/22/24 Based on record review and interview, the facility failed to provide behavioral health training (training that helps staff recognize and respond to various behavioral and mental health issues that residents may present with) for 1 (CNA #26) of 5 (RN #24, LPN #25, CNA #26, RN #27 and CNA # 28) staff sampled for training. This deficient practice could likely result in residents not receiving the services necessary to attain or maintain their physical, mental, and psychosocial (involving both psychological and social aspects) well-being. The findings are: A. Record review of the staff training records revealed CNA #26 did not complete training for behavioral health needs. B. On 05/19/25 at 2:48 PM, during an interview, the Human Resource Manager (HRM) confirmed that CNA #26 did not complete the training for the year 2025. The HRM confirmed that the training should be completed annually.