STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	325120	A. Building B. Wing	07/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fort Bayard Medical Center	41 Fort Bayard Road Santa Clara, NM 88026

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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure residents and/or their representatives were informed in advance of what medications they received and understood the reasons, risks, and benefits of the medications for 1 (R #17) of 3 (R #16, R #17, and R #18) 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:A. Record review of R #17's admission documents, no date revealed R #17 was admitted to the facility on [DATE]. B. Record review of R #17's physician order, dated 06/28/25, revealed an order for Lorazepam (medication used to treat anxiety disorders) 0.5 mg, on Mondays and Thursdays (shower days) for anxiety/agitation. C. Record review of R #17's entire medical record, no date revealed staff did not document a consent to take Lorazepam. D. On 07/10/25 at 2:17 PM, during an interview, the DON confirmed the following:1. R #17 had orders for Lorazepam for the diagnosis of anxiety.2. R #17's medical record did not contain consent for R #17 to take Lorazepam.3. Staff are expected to obtain written consent prior to resident starting any psychotropic medication (any drug that affects brain activities associated with mental processes and behavior).

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure residents did not receive psychotropic medications (group of drugs that affect behavior, mood, thoughts, or perception. Are used to treat a variety of conditions including anxiety, depression, bipolar disorder, and schizophrenia) unless the medication was medically necessary for 2 (R #17 and R #18) of 3 (R #16, R #17, and R #18) residents reviewed for unnecessary medications, when staff failed to ensure: 1. Psychotropic medications for R #17 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 ordered to be given as needed (PRN) for R #18 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. 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:R #17A. Record review of R #17's admission documents, no date revealed the following:1. R #17 was admitted to the facility on [DATE].2. With the following diagnoses: a. Vascular dementia, moderate, with psychotic disturbance (a stage of vascular dementia where cognitive decline is significant and accompanied by psychotic symptoms like hallucinations, paranoia, or delusions). B. Record review of R #17's physician order, dated 06/19/25 revealed an order for Lorazepam (medication used to treat anxiety disorders) 0.5 mg, on Mondays and Thursdays (shower days) for anxiety/agitation. C. Record review of R #17's MAR, dated June 2025, revealed R #17 took Lorazepam on the following dates:1. 06/19/252. 06/23/253. 06/26/254. 06/30/25 D. Record review of R #17's MAR, dated July 2025, revealed R #17 took Lorazepam on the following dates:1. 07/03/252. 07/07/25 E. Record review of R #17's entire medical record, no date, revealed R #17 did not have a diagnosis of anxiety. R #18F. Record review of R #18's admission documents, no date, revealed the following:1. R #18 was admitted to the facility on [DATE]. 2. With the following diagnoses: a. Unspecified dementia (a general term for a decline in mental ability severe enough to interfere with daily life), unspecified severity, with other behavioral disturbance. b. Insomnia (a common sleep disorder characterized by persistent difficulty falling asleep, staying asleep, or waking up too early, despite having adequate opportunities for sleep). G. Record review of R #18's physician's order, dated 07/03/25, revealed an order for Lorazepam every 4 hours as needed (PRN) for restlessness/anxiety/insomnia (difficulty sleeping), indefinitely (no end date). H. Record review of R #18's entire medical record, no date, revealed the medical record did not contain a rationale from the provider as to why R #18 needed PRN Lorazepam for longer than 14 days. I. On 07/10/25 at 2:17 PM, during an interview the DON confirmed the following:1. R #17 had an order for Lorazepam for the diagnosis of anxiety.2. R #17 did not have a diagnosis of anxiety.3. Staff are expected to ensure residents have an appropriate diagnosis prior to starting any medication.4. R #18 had an order for Lorazepam every 4 hours PRN for restlessness/anxiety/insomnia.5. R #17's order for PRN Lorazepam was for an indefinite length of time.6. R #18's medical record did not contain rationale from the provider as to why R #18 needed PRN Lorazepam for longer than 14 days. J. On 07/10/25 at 2:17 PM, during an interview, the DON confirmed the following:1. R #17 had an order for Lorazepam for the diagnosis of anxiety.2. R #17 did not have a diagnosis of anxiety.3. Staff are expected to ensure residents have an appropriate diagnosis prior to starting any medication.4. R #18 had an order for Lorazepam every 4 hours PRN for restlessness/anxiety/insomnia.5. R #17's order for PRN Lorazepam was for an indefinite length of time.6. R #18's medical record did not contain rationale from the provider for why R #18 needed PRN Lorazepam for longer than 14 days

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to report all injuries of unknown origin and the results of all investigations to the State Survey Agency for 1 (R #21) of 3 (R #19, R #20, and R #21) residents reviewed for falls. If the facility fails to report injuries of unknown origin and the results of investigations within five (5) business days to the State Agency, then the State Agency is unable to ensure residents have a safe environment. The findings are:A. Record review of R #21's admission documents, no date revealed R #21 was admitted to the facility on [DATE]. B. Record review of the facility's incident log, no date, revealed R #21 had an injury of unknown origin on the following dates:1. 06/22/25, bruise on chin measuring 5cm x 2 cm.2. 06/25/25, large scratch 51cm x .1 cm from shoulder to hip and skin tears to knees.3. 06/28/25, skin tear (possibly self-inflicted) to right shin 5.5cm x 2.5 cm. C. Record review of R #21's progress notes, multiple dates, revealed the following:1. On 06/22/25, R #21 was found to have a 5.0 cm x 2.0 cm bruise across the width of his chin. R #21 was unable to state how he received the injury.2. On 06/25/25, R #21 was found to have multiple injuries: a. R #21 had a long scratch from his shoulder blade down to his left hip that measured 51 cm x 0.1 cm. b. R #21had an abrasion (a superficial wound caused by rubbing or scraping the skin, often resulting in a scrape or brush burn) on his right shoulder above his collar bone that measured 2.5 cm x 2.0 cm. c. R #21 had multiple skin tears on his Left knee: i. One above R #21's kneecap that measured 2.5 cm x 2.0 cm. ii. One on the inner side of R #21's left kneecap that measured 4 cm x 0.2 cm. iii. One across the middle of R #21's kneecap that measured 2 cm x 0.2 cm. iv. R #21 was unable to state how he obtained the injuries.3. On 06/28/25, R #21 was found to have a scratch on his right shin that measured 5.5 cm x 2.5 cm x 0.1 cm. D. Record review of the facility's Incident Reports, multiple dates, revealed the following:1. Incident report form dated 06/23/25, for R #21's injury of unknown origin on 06/22/25.2. The incident report form did not have any information to indicate it was submitted to the state agency.3. There was no follow-up report regarding R #21's injury of unknown origin on 06/22/25.4. Incident report form, dated 06/25/25, for R #21's injury of unknown origin on 06/25/25.5. The incident report form did not have any information to indicate it was submitted to the state agency.6. There was no follow-up report regarding R #21's injury of unknown origin on 06/25/25.7. Incident report form dated 06/30/25, for R #21's injury of unknown origin on 06/28/25.8. The incident report form did not have any information to indicate it was submitted to the state agency.9. There was no follow-up report regarding R #21's injury of unknown origin on 06/28/25. E. On 07/10/25 at 1:31 PM, during an interview, the facility's Investigator stated the following:1. He completed the investigation report for R #21's injury of unknown origin on 06/22/25, 06/25/25, and 06/28/25 and submitted them to the state agency via fax.2. He completed the investigations for R #21's injury of unknown origin on 06/22/25, 06/25/25, and 06/28/25 and submitted the follow-up reports to the state agency via fax.3. He was unable provide a copy of the follow-up reports for R #21's injury of unknown origin on 06/22/25, 06/25/25, and 06/28/25 due to computer issues.4. He did not receive fax confirmation that the reports were submitted to the state agency.5. He did not have any documentation that the reports were submitted to SA. F. On 07/10/25 at 3:12 PM, during an interview, the state agency Complaint Lead Intake Coordinator confirmed the following:1. The state agency did not receive an initial report of R #21's injury of unknown origin on 06/22/25.2. The state agency did not receive a follow-up investigation report for R #21's injury of unknown origin on 06/22/25.3. The state agency did receive an initial report of R #21's injury of unknown origin on 06/25/25.4. The state agency did not receive a follow-up investigation report for R #21's injury of unknown origin on 06/25/25.5. The state agency did not receive an initial report of R #21's injury of unknown origin on 06/28/25.6. The state agency did not receive a follow-up investigation report for R #21's injury of unknown origin on 06/28/25.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure medical records were complete and accurate for 1 (R #18) of 3 (R #16, R #17, and R #18) residents reviewed for unnecessary medications.This deficient practice has the potential to negatively impact on the care staff provided to meet residents' needs due to missing or inaccurate records and resident information.The findings are:A. Record review of R #18's admission documents, no date, revealed the following:1. R #18 was admitted to the facility on [DATE]. 2. With the following diagnoses: a. Unspecified dementia (a general term for a decline in mental ability severe enough to interfere with daily life), unspecified severity, with other behavioral disturbances. b. Insomnia (a common sleep disorder characterized by persistent difficulty falling asleep, staying asleep, or waking up too early, despite having adequate opportunities for sleep). B. Record review of R #18's provider progress note, dated 05/04/25, revealed R #18 had a diagnosis of Moderate dementia with anxiety. C. On 07/10/25 at 2:21 PM, during an interview, the DON confirmed the following:1. R #18's provider documented R #18 had a diagnosis of Moderate dementia with anxiety.2. R #18's list of diagnoses did not include the diagnosis of Moderate dementia with anxiety.3. Staff are expected to update the residents' diagnoses list when a new diagnosis is added.