

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  325128	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  02/26/2026
NAME OF PROVIDER OR SUPPLIER  Artesia Healthcare & Rehabilitation Center, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE  1402 West Gilchrist Ave Artesia, NM 88210	

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)
<p>F 0582</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered.</p> <p>Based on record review and interview the facility failed to ensure residents were only liable for services rendered for 1 (R #64) of 4 (R #3, R #8, R #59 and R #64) residents reviewed for discharge when the facility failed to refund the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge. The findings are:A. Record review of R #64's Electronic Health Record (EHR) revealed R #64 was discharged on 10/22/25.B. On 02/26/26 at 12:22 pm, during an interview with the Business Office Manager, she confirmed1. R #64 was owed a refund for October and November of 2025, 2. The facility received payment in November and should not have,3. The facility failed to refund October within 30 days of discharge,4. The refund was mailed to R #64 on 02/20/26, approximately 120 days after discharge.</p>

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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