

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

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 07/29/2026
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)		
F 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observation, and interviews, the facility failed to ensure residents were free from abuse for 2 (R #9 and R #10) of 2 (R #9 and R #10) residents reviewed for abuse, when:1. Licensed Practical Nurse (LPN) #3 verbally abused and R #10.2. The accused staff member was no prohibited from providing resident care during the investigation putting other residents at risk for abuse. 3. LPN #3 has since confronted R #9 (reporter and witness to the verbal abuse of R #10) which could be considered an attempt at intimidation. This deficient practice likely resulted in R #10 experiencing psychosocial harm in the form of fear, anxiety, tearfulness, sleep disturbance, emotional distress, and concern for retaliation. The findings are:A. Record review of the facility's Abuse Policy, dated 02/29/24, revealed the following:1. If resident abuse, neglect, exploitation, misappropriation of the resident's property or injury of unknown source was suspected, the suspicion must be reported immediately to the administrator and to other officials according to state law.2. Immediately was defined as within two hours of an allegation involving abuse or results in serious bodily injury, or within 24 hours of an allegation not involving abuse or resulting in serious bodily injury.3. Resident abuse was defined as the willful infliction of injury, unreasonable confinement, intimidation, or punishment of a resident resulting in physical harm or pain, mental anguish, deprivation of goods or services necessary to maintain physician, mental or psychosocial well-being. Resident abuse included verbal abuse, mental abuse, sexual abuse, physical abuse, including abuse facilitated or enabled through use of technology.4. Verbal abuse was defined as the use of oral, written, or gestured language including disparaging or derogatory terms directed at a resident or their family, or spoken within their hearing distance, regardless of the resident's comprehend or disability.5. Mental abuse was defined as, but not limited to, humiliation, harassment, threats of punishment or withholding treatment or services.6. When an employee was suspected of abuse of a resident, the employee would be placed on immediate suspension while the matter was under investigation.7. Results of the investigation would be submitted to the SA.8. When the investigation showed a violation of facility policy other than abuse, the employee would be subject to disciplinary action appropriate to the violation. B. Record review of R #9's quarterly Minimum Data Set (MDS; a standardized assessment used to evaluate a resident's clinical status and care needs) assessment, dated 07/18/26 revealed the following:1. R #9 was admitted to the facility on [DATE].2. R #9 had a Brief Interview for Mental Status (BIMS; a standardized cognitive screening assessment) score of 15, indicating the resident was cognitively intact.3. R #9 had the following diagnoses:Seizure disorder (a disorder in which nerve cell activity in the brain is disturbed, causing seizures),Anxiety disorder (feelings of fear or apprehension),Depression (a mood disorder that causes a persistent feeling of sadness and loss of interest). C. Record review of R #10's quarterly MDS assessment, dated 04/23/26, revealed the (continued on next page)		

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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F 0600 Level of Harm - Actual harm Residents Affected - Few	following:1. R #10 was admitted to the facility on [DATE].2. R #10 had a Brief Interview for Mental Status (BIMS; a standardized cognitive screening assessment) score of 15, indicating the resident was cognitively intact.3. R #10 had the following diagnoses:Anxiety disorder,Bipolar disorder (a disorder associated with episodes of mood swings ranging from depressive lows to manic highs),Seizure disorder,Type 2 diabetes mellitus (DM2, a metabolic disorder leading to elevated blood glucose),Need for assistance with personal care.D. Record review of facility grievance reports revealed the following reports:1. Dated 07/13/26, R #9 stated LPN #3 was condescending and was rude to him and another resident over the weekend. The grievance form did not indicate who the other resident was. 2. Dated 07/13/26, documented R #10's allegations as:a. LPN #3 called her a meth head, and told her, She has no teeth because she is a meth head, no home because she is a meth head, and lives in the nursing home because she is a meth head.b. Staff sleep while on night shift.c. R #10 was afraid to take medications from LPN #3 because she felt he would hurt her.3. Dated 07/14/26, R #10 alleged LPN #3 spoke to her in a condescending manner and told her, Here are your narcotics, You're a meth head just waiting for your meds, and You are here because you can't work with no teeth due to use of meth. E. Record review of R #10's progress notes dated 07/12/26 revealed LPN #3 documented, R #10 is upset with nurse for unknown reasons. R #10 was verbally aggressive and paranoid for the last two night shifts. Not responsive to staff interventions and refused care, refused medications and redirections. R #10's medication list to be reviewed per administrator notification.F. Record review of the facility's incident summary/investigation report, not dated, revealed the following:1. R #10 alleged LPN #3 made derogatory remarks towards her and raised concerns regarding the conduct of night shift staff. 2. The following individuals were interviewed; the dates of the interviews were not provided.LPN #2,LPN #3,Registered Nurse (RN) #2,Certified Medication Aide (CMA) #3,CNA #20,R #10.3. ConclusionThe allegation was partially substantiated following the results of the investigation. Evidence supported the allegation that LPN #3 made an inappropriate remark referencing methamphetamine use during verbal exchange with R #10.The investigation did not support the allegation involving multiple statements.LPN #3's response did not meet facility expectations for professional interactions with residents.4. Document titled, Employee Education for Professional Communication During Resident Interactions completed on 07/27/26, was attached to the report and indicated LPN #3's retraining on how to communicate with residents.5. There was no evidence that LPN #3 was suspended (unable to work) during the investigation period. G. Record review of LPN #3's timecard revealed LPN #3 worked the 6:00 pm to 6:00 am shift on 07/15/26, 07/16/26, 07/21/26, and 07/23/26.H. Record review of LPN #3's training file revealed Abuse and Exploitation Inservice was completed on 05/31/26. There was no other record of abuse training received. I. On 07/29/26 at 11:30 am, during an interview, R #9 stated LPN #3 was rude to him and other residents. R #9 stated he heard LPN #3 talked really bad to R #10. R #9 stated he could not remember the exact date this happened but said he was in the hallway one day and heard LPN #3 telling R #10 she had no teeth because she was a drug addict. R #9 stated he filed a grievance the Monday following the incident. R #9 stated LPN #3 has called him stupid and told him, They don't have a pill for that. R #9 stated he was upset when LPN #3 told him this because he did not deserve to be spoken to in that manner. R #9 stated he had not been interviewed regarding the incident involving R #10. R #9 stated after he filed the grievance LPN #3 told him, Thanks for writing a grievance on me. R #9 stated he does not feel like LPN #3's comments affected him personally. R #9 will continue to file grievances for inappropriate staff actions even though he shouldn't have to be the one addressing the staff's verbal abuse. J. On 07/23/26 at 2:14 pm, during an interview and observation, R #10 stated during the night shift of 07/11/26, LPN #3 made the following statements (continued on next page)		

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F 0600 Level of Harm - Actual harm Residents Affected - Few	towards her:1. I know you want your narcotics cause you used to be a meth head. 2. You don't have any teeth because you used to be a meth head.3. You probably lost your kids because of meth use.R #10 stated there were no other staff present when LPN #3 during the incident but there were other residents. R #10 stated she has asked the administrator if her concerns had been addressed and the administrator told her she would talk to him. R #10 confirmed that there had been no other communication with her regarding the outcome of the investigations. R #10 began to cry and stated she did not feel comfortable around him [LPN #3]. She stated she was embarrassed because she had been clean for two years, and she believed it was not any of LPN #3's business to speak about her history. She stated she had a difficult time sleeping and had nightmares when he [LPN #3] worked, and she did not feel safe with him [LPN #3]. R #10 stated she refused medications when he [LPN #3] has been the only person who can give meds because she does not trust him [LPN #3] and is afraid of retaliation. K. On 07/28/26 at 4:31 pm, during an interview, the Administrator (ADM) #1 stated the facility was required to report abuse, neglect, significant injuries of unknown origin and misappropriation of funds to the state agency. ADM #1 stated her expectation was for staff to follow facility policies, and all facility staff are trained in preventing, recognizing and reporting abuse and neglect as part of the facility ongoing training program. ADM #1 stated she is the incident coordinator, and it is her responsibility to ensure residents are free from abuse. She stated these allegations {between R #10 and LPN #3} were not reported, and LPN #3 was not suspended because she did not feel R #10 allegations were enough to determine abuse nor did LPN 3's conduct meet the criteria for abuse. ADM #1 stated that it is not ok for staff to speak to residents in degrading manner or be humiliated. The ADM refused to identify LPN #3's conduct as verbal abuse. She stated LPN #3 was removed from R #10's care but was not suspended and continued to work his regular schedule.L. On 07/29/26 at 12:48 pm, during an interview, the Regional Quality Mentor (RQM) stated there were no records of any corrective actions completed for LPN #3. The RQM was not aware of R #10's allegations and stated ADM #1 should have reported the allegation and findings of the investigation to the SA as required.		

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure services provided by the nursing facility meet professional standards of quality. Based on record review and interview, the facility failed to provide services that meet professional standards of quality when Administrator (ADM) #1 performed duties outside of her scope of practice (nursing duties). This deficient practice has the potential to put all 53 residents residing in the facility according to the census provided by the Business Office Manager (BOM) on 07/23/26, at risk of receiving inappropriate care that could harm the residents' health. The findings are: A. Record review of the Administrator Policy Statement, revised March 2021, revealed the following: 1. The Administrator was responsible for implementing established resident care policies, personnel policies, safety and security policies and other operational policies and procedures necessary to remain in compliance with current laws, regulations and guidelines governing long-term care facilities. 2. Ensure adequate number of personnel are employed to meet the residents' needs. B. Record review of a text message, dated 07/08/26, revealed an image of ADM #1 in the dining area sitting with R #2. ADM #1 was putting on gloves, with a sharp's container (a box designated for disposal of needles and other sharp objects) next to her. R #2 was holding his finger out. C. Record review of R #2's comprehensive care plan, dated 06/17/26, revealed the following: 1. R #2 had a diagnosis of diabetes mellitus (DM; a disease in which the body cannot make or properly use insulin). 2. If R #2 experienced hypoglycemia (low blood sugar, normal blood sugar measurement is 70 to 99 mg/dL), facility staff were to assist with four ounces of juice and check R #2's blood sugar every 15 minutes for 45 minutes. 3. If R #2 experienced hyperglycemia (high blood sugar) facility staff were to give glucagon (a medication to help regulate blood sugar), check R #2's blood sugar 15 minutes later and notify the medical director if needed. D. On 07/23/26 at 12:54 pm, during an interview, the Ombudsman stated she received an anonymous complaint on 07/08/26 alleging no nurse was on shift on 07/08/26 and ADM #1 was sitting at the nurse's station. E. On 07/28/26 at 8:36 am, during an interview, R #2 could not recall if ADM #1 had ever given him medications or checked his blood sugar. F. On 07/24/26 at 1:38 pm, during an interview, R #7 stated three weeks ago she saw ADM #1 assist other residents in the facility with medications because no nurse was in the facility. G. On 07/24/26 at 1:56 pm, during an interview, Certified Nurse Aide (CNA) #23 stated there was no nurse in the facility for three hours on 07/08/26. She stated ADM #1 was in the dining area checking vital signs [body temperature, pulse rate, respiration rate (rate of breathing), oxygen saturation (amount of oxygen in the blood), and blood pressure] and checking blood sugars. She stated she was not sure if ADM #1 was certified to complete these duties. H. On 07/24/26 at 1:50 pm, during an interview, Anonymous Staff (AS) #3 stated there was no nurse in the facility from 3:00 pm to 6:00 pm on 07/08/26. AS #3 stated ADM #1 administered medications to the residents. AS #3 was not sure how many times the facility operated without a nurse in the building. AS #3 was not sure what ADM #1's certifications were but she did not think ADM #1 was certified to perform nursing duties. I. On 07/24/26 at 2:17 pm, during an interview, AS #5 stated one day during the week after the holiday on 07/04/26, ADM #1 was in the dining area checking vital signs and blood sugars for the residents. AS #5 stated she was not sure how many times the facility had operated without a nurse in the building. AS #5 was not sure what ADM #1's certifications were but she did not think ADM #1 was certified to perform nursing duties. J. On 07/28/26 at 2:12 pm, during an interview, CNA #18 stated she saw ADM #1 administer medications to residents on 07/08/26. She stated she could not recall which residents and did not know if ADM #1 was certified to administer medications. CNA #18 stated she was not sure how many times the facility had been run without a nurse in the building. CNA #18 was not sure what ADM #1's certifications were but she did not think ADM #1 was certified to carry out nursing duties. K. On (continued on next page)		

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	07/28/26 at 4:31 pm, during an interview, ADM #1 stated she is a Certified Nursing Home Administrator (NHA) and a CNA but was not a licensed nurse. ADM #1 stated checking vital signs and blood sugars or administering medications is not within the scope of practice as an NHA or CNA and was within the scope of practice of a licensed nurse. ADM #1 stated she never checked vital signs or blood sugars or administered medications to any residents. She stated her expectation was for staff to report any concerns regarding their administrative duties to cooperate compliance. L. On 07/29/26 at 11:18 p.m., during an interview, the Regional Quality Mentor (RQM) stated that she had placed ADM #1 on administrative leave pending investigation after speaking with several facility staff about concerns related to ADM #1. She stated she had not been aware of allegations ADM #1 had assisted residents by performing nursing duties. She stated all staff had been trained to provide services consistent with professional standards of care at the facility.		

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. Based on record review and interview, the facility failed to: Maintain sufficient nursing staffing to ensure the highest practicable physical, mental, and psychosocial well-being of each resident. Have Licensed Nursing Coverage 24-hours/day. This failure has the potential to affect all 54 residents (residents were identified by the facility census list provided by the Business Office Manager on 07/23/26). These deficient practices are likely to negatively impact resident safety, comfort, and impede processes such as timely showers and appropriate assistance with care. The findings are: A. Record review of the facility's assessment, dated 10/28/26, revealed the facility needs the following daily (24 hours) resources to provide competent support and care for residents: 1. Four licensed nurses providing direct care, 2. Six nurse aides, 3. Four nursing personnel with administrative duties. B. Record review of a grievance report, dated 07/13/26, revealed R #9 claimed he requested a shower during the night shift (6:00 pm to 6:00 am) over the prior weekend and was told he could not shower because there were only two Certified Nurse Aides (CNAs) available, so there was not enough staff to provide the shower. C. Record review of staff timecards, dated 06/24/26- 7/24/26, revealed the following dates when the facility did not maintain the staffing levels identified in its facility assessment to provide competent support and care for the residents: On 06/27/26, two CNA's provided direct care during the night shift. On 06/29/26, one nurse provided direct care during the day, and one nurse provided direct care during the night. On 06/30/26, the facility failed to have a nurse to provide care during the day. On 07/02/26 two CNA's provided direct care during the night shift. On 07/05/26, one nurse provided direct care during the night shift. On 07/08/26, the facility failed to have a nurse to provide care during the day, and one nurse provided direct care during the night shift. On 07/10/26, one nurse provided direct care during the night shift. On 07/11/26, one nurse and two CNA's provided direct care during the night shift. On 07/12/26, one nurse provided direct care during the night shift. On 07/14/26, one nurse provided direct care during the night shift. On 07/17/26, one nurse provided direct care during the day shift, and one nurse provided direct care during the night shift. On 07/18/26, the Director of Nursing (DON) provided direct care during the day shift, and the facility failed to have a nurse to provide care during the night. On 07/19/26, the DON provided direct care during the day shift, and the facility failed to have a nurse to provide care during the night. On 07/22/26, one nurse and two CNA's provided direct care during the night shift. D. On 07/29/26 at 11:30 pm, during an interview, R #9 stated he was frustrated because he waited over an hour for staff to respond to his call light. He stated Administrator (ADM) #1 assisted with providing showers because there were not enough staff available. R #9 stated this was the only time this had happened to him, but he noticed there had not been as many staff in the building as there used to be. E. On 07/23/26 at 2:14 pm, during an interview, R #10 stated on 07/19/26 the DON was sent to the hospital after working 36 hours straight. F. On 07/24/26 at 7:43 am, during an interview, Administrator (ADM) #2 stated he was the Administrator from a sister facility but was currently in the building helping as a licensed nurse. ADM #2 stated this was the first time he covered as a nurse in the facility. ADM #2 stated he was unsure of the facility's staffing practices. ADM #2 stated he expected every facility to staff the building according to the facility assessment. G. On 07/24/26 at 8:41 am, during an interview, Registered Nurse (RN) #4 stated she had been working a lot of hours but did not provide further clarification. H. On 07/24/26 at 12:18 pm, during an interview, ADM #1 stated LPN #2 is currently doing infection control and wound care. She stated the DON is out due to being hospitalized and the Regional Quality Mentor (RQM) is currently covering DON duties. I. On 07/27/26 (continued on next page)		

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	at 1:41 pm, during an interview, Licensed Practical Nurse (LPN) #2 stated she had worked on the floor a lot lately because the facility did not have enough nurses. LPN #2 stated she had not been able to complete her administrative duties as a Minimum Data Set (standardize assessment tool used to evaluate resident care and functional abilities) Coordinator because she needed to provide direct care, wound care, and infection reports. LPN #2 stated corporate staff complete the MDS duties because she could not. J. On 07/28/26 at 12:40 pm, during an interview, CNA #18 stated the facility was short-staffed and said it was a normal thing. She stated her job was affected when it came to documentation because she did not always have time to complete charting (documentation of the care and services she has provided to residents). K. On 07/28/26 at 1:04 pm, during an interview, CNA #16 stated the facility was short staffed almost daily, and residents were affected because she did not have time to assist every resident with showers. She stated there were times when residents became mad and upset because they were told they could not get a shower due to not having enough staff. L. On 07/28/26 at 1:13 pm, during an interview, CNA #3 stated the facility was short staffed, and the residents were affected because CNAs could not complete all job responsibilities to provide quality care. She stated beds sometimes did not get made, showers had to be delayed, and charting did not get completed. She stated staff were stressed and the residents sensed it. M. On 07/28/26 at 1:32 pm, during an interview, CNA #21 stated she was primarily hired as a shower aide to shower residents, but she had to work the floor often because the facility was short staffed. She stated she could not do her job when the facility was short staffed, and she had to delay residents' shower schedules. N. On 07/28/26 at 2:58 pm, during an interview, LPN #4 stated the facility had struggled with staffing for a while. She stated some shifts did not have full-time CNAs, and some had only one nurse. She stated this created problems because, as a nurse, she could assist CNAs with their duties, but CNAs could not assist with nursing duties. She stated when she had to help CNAs, she experienced delays in completing wound care and medication passes. She stated she often stayed one or two hours late to finish her charting. O. On 07/23/26 at 12:54 pm, during an interview, the Ombudsman stated she had received an anonymous complaint on 07/08/26 reporting no nurse was on shift that day. P. On 07/24/26 at 1:56 pm, during an interview, CNA #23 stated the facility did not have a nurse on shift for three hours on 07/08/26. She stated LPN #2 was the only nurse on shift and she left at 2:30 pm. She stated RN #4 arrived at the facility at 5:00 pm. Q. On 07/28/26 at 2:12 pm, during an interview, CNA #18 stated on 07/08/26 there were no nurses on shift for three hours. She stated LPN #2 was the only nurse in the building that day and she left early around 3:00 pm. She stated RN #4 did not arrive at the facility until 6:00 pm. She stated on 07/19/26 the DON became ill and looked like she might be having a heart attack. She stated the DON left the facility at 4:00 pm. She stated there were no nurses on shift when the DON left the facility. She stated RN #4 arrived at the facility at 5:00 pm. R. On 07/28/26 at 1:59 pm, during an interview, CNA #3 stated on 07/19/26 the DON was the only nurse on shift, left around 3:30 pm due to a health emergency, and no nurse was on shift until about 5:00 pm. She stated the DON had been working for roughly 33 hours straight when she had the health emergency on 07/19/26. She stated on 07/08/26 there was no nurse on the floor for three hours. She stated LPN #2 left at 2:00 pm and RN #4 arrived at 5:00 pm. S. On 07/28/26 at 3:28 pm, during an interview, LPN #2 stated she had been working on the floor rather than performing administrative duties. She stated she was salaried and not required to clock in. She stated she worked on 07/08/26 and left at 2:30 pm due to a court-ordered legal matter. She stated RN #4 was in the DON's office, and she was going to inform RN #4 she was leaving when ADM #1 told her to go ahead and leave, adding ADM #1 would notify RN #4. T. On 07/28/26 at 4:31 pm, during an interview, ADM #1 stated salaried staff were not expected to clock in, and LPN #1 was working as a floor nurse. (continued on next page)		

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F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Post nurse staffing information every day. Based on observation, record review, and interview, the facility failed to post nurse staffing data daily at the beginning of the shift to include the following:- Facility name.- The current date.- The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift.1. Registered nurse,2. Licensed practical nurse,3. Certified nurse aides,4. Resident census.This deficient practice has the potential to affect all 53 residents identified by the census provided by the Business Office Manager on 07/23/26. This could likely result in residents and visitors not having the updated staffing information readily available. The findings are:A. Record review of the facility's assessment, dated 10/28/26, revealed the facility needs the following daily (24 hours) resources to provide competent support and care for residents:1. Four licensed nurses providing direct care,2. Six nurse aides,3. Four nursing personnel with administrative duties. B. Record review of the nurse staffing data sheet, dated 07/19/26, revealed no nurse on the night shift and only 11.5 hours of nursing coverage. C. On 07/24/26 at 8:35 am, during an observation and interview, the posted nurse staffing data sheet, dated 07/24/26, did not include the resident census. The receptionist stated the current posted nurse staffing data sheet dated 07/24/26 did not include the resident census. D. On 07/24/26 at 12:18 pm, during an interview, Administrator (ADM) #1 stated the nurse staffing data sheets provided were inaccurate and did not reflect actual hours worked because the receptionist completed the forms but does not know how to get the correct hours for nursing staff. ADM #1 stated she should have trained the receptionist to complete the nurse staffing data sheets prior to having her complete and post the sheets.		

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 07/29/2026
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.			
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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observation, and interview, the facility failed to implement an ongoing infection prevention and control program (a program that is used to prevent, recognize, and control the onset and spread of infections) when the facility failed to ensure Enhanced Barrier Precaution (EBP; an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employs targeted gown and glove use during high contact resident care activities) signs were posted and visible outside of resident rooms. This deficient practice has the potential to affect all 53 residents identified on the facility census provided by the Business Office Manager on 07/23/26. This deficiency is likely to put residents at risk of contracting and spreading infections, hospitalization, and death. The findings are: A. Record review of the facility's Enhanced Barrier Precautions Policy, dated 09/11/25, revealed the following: 1. EBP was required for residents with wounds, indwelling medical devices (an instrument or tube left inside a patient's body), and colonized multidrug-resistant organisms (MDRO; a germ that is resistant to many antibiotics). 2. Signage should be posted outside of resident rooms indicating the requirements for EBP and what Personal Protective Equipment (PPE; protective clothing, face masks, goggles, or other garments or equipment designed to protect the wearer's body from injury or infection) was necessary. B. On 7/23/26 at 12:09 pm, during an observation of the residents' rooms in the facility, revealed the following: 1. room [ROOM NUMBER] had PPE hanging on the door, but no visible sign was posted, 2. room [ROOM NUMBER] had PPE hanging on the door, but no visible sign was posted, 3. room [ROOM NUMBER] had PPE hanging on the door, but no visible sign was posted, 4. room [ROOM NUMBER] had PPE hanging on the door, but no visible sign was posted. C. On 07/23/26 at 2:58 pm, during an interview, Anonymous Staff (AS) #3, stated resident room [ROOM NUMBER] did not have an EBP sign posted on the door. AS #3 stated there should be one because the resident in the room had an indwelling device. D. On 7/23/26 at 12:29 pm, during an interview, the Social Services Director (SSD) stated resident room [ROOM NUMBER] did not have an EBP sign posted. The SSD stated this room should have an EBP sign visibly posted due to the resident's infection. The SSD stated nurses on shift are required to ensure EBP signs were posted on rooms where EBP was required. E. On 7/23/26 at 12:34 pm, during an interview, the Business Office Manager (BOM) stated resident room [ROOM NUMBER] did not have an EBP sign posted on the door and should have had one due to the resident having wounds. She stated resident room [ROOM NUMBER] did not have an EBP sign posted on the door and should have had one due to the resident's indwelling device. The BOM stated the nurses on shift were responsible for ensuring EBP signs were posted on rooms where EBP was required. F. On 07/28/26 at 4:01 pm, during an interview, the Regional Quality Mentor stated her expectation was for any resident with an unnatural opening such as an indwelling medical device, open wound, or history of MDRO to have an EBP sign visibly posted and PPE available. She stated nurses on shift were all responsible for ensuring the required rooms had the appropriate signs on the resident room doors. She stated the Director of Nursing (DON) or designee should ensure the correct signs were posted on the correct doors.		

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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. Based on record review and interview, the facility failed to report incidents involving allegations of abuse or neglect to the State Agency (SA) no later than 24 hours after the allegation was made, for 2 (R #9 and R #10) of 3 (R #9, R #10, and R #13) residents reviewed for abuse. If the facility fails to report allegations of abuse or neglect to the State Agency, then residents are at risk for delayed investigation to identify or rule out abuse or neglect, lack of timely interventions to prevent resident harm. The findings are: A. Record review of the facility's Abuse Policy, dated 02/29/24, revealed the following: 1. If resident abuse, neglect, exploitation, misappropriation of the resident's property or injury of unknown source was suspected, the suspicion must be reported immediately to the administrator and to other officials according to state law. 2. Immediately was defined as within two hours of an allegation involving abuse or results in serious bodily injury, or within 24 hours of an allegation not involving abuse or resulting in serious bodily injury. 3. Resident abuse was defined as the willful infliction of injury, unreasonable confinement, intimidation, or punishment of a resident resulting in physical harm or pain, mental anguish, deprivation of goods or services necessary to maintain physician, mental or psychosocial well-being. Resident abuse included verbal abuse, mental abuse, sexual abuse, physical abuse, including abuse facilitated or enabled through use of technology. 4. Verbal abuse was defined as the use of oral, written, or gestured language including disparaging or derogatory terms directed at a resident or their family, or spoken within their hearing distance, regardless of the resident's comprehend or disability. 5. Mental abuse was defined as, but not limited to, humiliation, harassment, threats of punishment or withholding treatment or services. 6. When an employee was suspected of abuse of a resident, the employee would be placed on immediate suspension while the matter was under investigation. 7. Results of the investigation would be submitted to the SA. 8. When the investigation showed a violation of facility policy other than abuse, the employee would be subject to disciplinary action appropriate to the violation. R #9B. Record review of facility grievances, dated 07/13/26, revealed a grievance form where R #9 alleged LPN #3 was condescending and was rude to him and another resident. The grievance from did not indicate who the other resident was. C. On 07/29/26 at 11:30 am, during an interview, R #9 stated the LPN #3 was rude to him and other residents. R #9 stated he heard LPN #3 talked really bad to R #10. R #9 stated he could not remember the exact date this happened but said he was in the hallway one day and heard LPN #3 telling R #10 she had no teeth because she was a drug addict. R #9 stated he filed a grievance the Monday following the incident. R #9 stated LPN #3 has called him stupid and told him, They don't have a pill for that. R #9 stated he was upset when LPN #3 told him this because he did not deserve to be spoken to in that manner. R #9 stated he was not interviewed regarding his grievance but LPN #3 approach him after said, Thanks for writing a grievance on me. However, does not feel like LPN's comments have affected him personally and will continue to file grievances. R #10D. Record review of facility grievance reports revealed the following: 1. A report, dated 07/13/26, documented R #10's allegations: LPN #3 called her a meth head, and told her, She has no teeth because she is a meth head, no home because she is a meth head, and lives in the nursing home because she is a meth head. Staff sleep while on night shift. R #10 was afraid to take medications from LPN #3 because she felt he would hurt her. 2. A report, dated 07/14/26, R #10 alleged LPN #3 spoke to her in a condescending manner and told her, Here are your narcotics, you're a meth head just waiting for your meds, and You are here because you can't work with no teeth due to use of meth. E. Record review of the facility's staffing timecards revealed the following staff worked the night shift, (continued on next page)		

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	6pm-6am, on 07/11/26:1. LPN #32. Certified Nurse Aide (CNA) #143. CNA #20F. Record review of an incident summary/investigation report, not dated, revealed the following:1. R #10 alleged LPN #3 made derogatory remarks towards her and raised concerns regarding the conduct of night shift staff. 2. The following individuals were interviewed; however, the dates of the interviews were not provided.LPN #2,LPN #3,Registered Nurse (RN) #2,Certified Medication Aide (CMA) #3,CNA #20,R #10.3. ConclusionThe investigation determined the allegation was partially substantiated. Evidence supported LPN #3 made an inappropriate remark referencing methamphetamine use during verbal exchange with R #10.The investigation did not support the allegation involving multiple statements.LPN #3's response did not meet facility expectations for professional interactions with residents.4. Document titled, Employee Education for Professional Communication During Resident Interactions completed on 07/27/26, was attached to the report.G. Record review of LPN #3's training file revealed the following LPN #3 completed Abuse and Exploitation Inservice on 05/31/26.H. On 07/23/26 at 2:14 pm, during an interview and observation, R #10 stated during the night shift of 07/11/26, LPN #3 made the following statements towards her:1. I know you want your narcotics cause you used to be a meth head.2. You don't have any teeth because you used to be a meth head.3. You probably lost your kids because of meth use.R #10 stated there were no other staff present when LPN #3 during the incident but there were other residents. R #10 stated she has asked the administrator if her concerns had been addressed and the administrator told her she would talk to him. R #10 began to cry and stated she did not feel comfortable around him. She stated she was embarrassed because she had been clean for two years, and she believed it was not any of LPN #3's business to speak about her history. She stated she had a difficult time sleeping and had nightmares when he worked, and she did not feel safe with him. R #10 stated she refused medications when he has been the only person who can give meds because she does not trust him and is afraid of retaliation. I. On 07/28/26 at 4:31 pm, during an interview, the Administrator (ADM) #1 stated the facility was required to report abuse, neglect, significant injuries of unknown origin and misappropriation of funds to the state agency. ADM #1 stated her expectation was for staff to follow facility policies, and all facility staff are trained in preventing, recognizing and reporting abuse and neglect as part of the facility ongoing training program. ADM #1 stated she is the incident coordinator, and it is her responsibility to ensure residents are free from abuse. She stated these allegations were not reported to the SA, and LPN #3 was not suspended because she did not feel R #10 allegations were enough to determine abuse nor did LPN 3's conduct meet the criteria for abuse. ADM #1 stated that it is not ok for staff to speak to residents in degrading manner or be humiliated. ADM #1 refused to confirm if allegations should be reported as outlined in the facility policy. She refused to identify LPN #3's conduct as verbal abuse as defined in the facility policy. She stated LPN #3 was removed from R #10's care but was not suspended and continued to work his regular schedule.		