

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 0552</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure that residents are fully informed and understand their health status, care and treatments.</p> <p>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 3 (R #46, R #55, and R #60) of 6 (R #1, R #7, R #9, R #46, R #55 and R #60) 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#46A. Record review of R #46's physician's orders revealed an order dated 06/06/23 for Melatonin (a supplement), nine milligrams (mg) to be given by mouth at bedtime for insomnia (a common sleep disorder).B. Record review of R #46's medical record revealed no consent form for the use of Melatonin.C. On 02/26/26 at 2:54 pm, during an interview with the Director of Nursing (DON), she confirmed staff did not obtain the required consent form for the use of Melatonin prior to R #46 using of medication. The DON confirmed that staff are expected to complete the psychotropic medication (psychotropic medication; any drug that affects brain activities associated with mental processes and behavior) consent forms prior to the resident starting psychotropic medications.R #55D. Record review of R #55's physician's orders revealed the following:1. An order dated 07/09/25 for Melatonin, five mg to be given by mouth one time a day for insomnia.2. An order dated 12/30/25 for Alprazolam (anti-anxiety medication), one mg to be given by mouth three times a day for anxiety/restlessness.E. Record review of R #55's medical record revealed no consent forms for the use of Melatonin and Alprazolam.F. On 02/26/26 at 2:54 pm, during an interview with the DON, she confirmed staff did not obtain the consent form for the use of Melatonin and Alprazolam for R #55 prior to the use of medication. The DON confirmed that staff are expected to complete the psychotropic medication consent form prior to the resident starting psychotropic medications and did not.R #60G. Record review of R #60's physician's orders revealed the following:1. An order dated 02/17/26 for Melatonin, mg to be given by mouth at bedtime for Insomnia.2. An order dated 02/17/26 for Olanzapine (anti-psychotic medication), a total of five mg to be given by mouth in the morning for schizophrenia (a disorder that affects an individual's ability to think, feel, and behave clearly).3. An order dated 02/19/26 for Olanzapine (anti-psychotic medication), fifteen mg to be given by mouth at bedtime for schizophrenia.4. An order dated 07/17/26 for Gabapentin (anti-convulsant medication), 100 mg to be given by mouth three times a day for pain/bipolar disorder (a disorder associated with episodes of mood swings ranging from depressive lows to manic highs).H. Record review of R #60's medical record revealed there were no consent forms for the use of Melatonin, Olanzapine, and Gabapentin.I. On 02/26/26 at 2:54 pm, during an interview with the DON, she confirmed staff did not obtain the consent forms for the use of Melatonin, Olanzapine, and Gabapentin for R #60 prior to the use of medications. The DON confirmed that staff are expected to complete the psychotropic medication consent form prior to the resident starting psychotropic medications.</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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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interviews, the facility failed to maintain a clean, safe, and comfortable environment for 11 (R #1, R #4, R #20, R #25, R #28, R #32, R #46, R #50, R #51, R #55, and R #61) of 15 (R #1, R #2, R #4, R #18, R #20, R #25, R #28, R #32, R #42, R #46, R #50, R #51, R #55, R #61, and R #63) residents reviewed when staff failed to:1) Repair broken outlet covers in resident rooms #301 and #305.2) Repair damaged drywall in resident rooms #203, #208, #209, #212, #301, #302 and #305.3) Empty trash timely room [ROOM NUMBER].4) Repair or repaint handrails throughout the building.Failure to maintain the building in a clean and comfortable manner is likely to result in unsafe conditions and prevent residents from enjoying everyday activities. These deficient practices could likely result in residents feeling frustrated, embarrassed, and unimportant. The findings are:Broken/Missing outlet coversA. On 02/22/26 at 12:22 pm, a random observation of residents' rooms revealed:- room [ROOM NUMBER] had a missing outlet cover on the wall near the bed.- room [ROOM NUMBER] had a missing outlet cover on the wall by the air conditioning unit.- room [ROOM NUMBER] had a broken outlet cover on the wall by the bed.Damaged DrywallB. On 02/22/26 at 12:43 pm, a random observation of resident rooms revealed:- room [ROOM NUMBER] had a large crack on the wall from floor to ceiling and chipped paint and scuff marks around the bottom of the wall, bottom of closet and bottom near bathroom door.- room [ROOM NUMBER] had damage to drywall, chipped paint and scuff marks around the bottom of the wall and the bottom of closet.- room [ROOM NUMBER] had damage to drywall, chipped paint and scuff marks around the bottom of the wall and bottom of closet. -room [ROOM NUMBER] had damage to drywall, chipped paint and scuff marks around the bottom of the wall and bottom of closet.- room [ROOM NUMBER] had a visible hole approximately the size of a quarter in the wall near bed.TrashC. On 02/23/26 at 12:50 pm, a random observation of resident room [ROOM NUMBER] revealed the trash was overflowing out of the trash bin and onto the floor.HANDRAILSD. On 02/22/25 at 9:55 am during an observation of the 100 hall, 200 hall, and 300 hall revealed the handrails were scuffed and chipped with paint missing in many places on the handrail.E. On 2/22/26 at 10:00 am during an interview Licensed Practical Nurse (LPN) #2, she confirmed the handrails needed to be touched up with paint due to the peeling and chipping.F. On 02/24/26 2:37 pm during an interview with Director of Nursing (DON) she stated the facility should be safe, clean, neat and orderly at all times.</p>		

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<p>F 0605</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function.</p> <p>**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) unless the medication was medically necessary for 2 (R #55 and R #60) of 3 (R #3, R #55 and R #60) residents reviewed for unnecessary medications, when staff failed to ensure psychotropic medications were necessary to treat a specific condition as diagnosed and documented in the clinical record. This deficient practice could likely lead to adverse drug effects and poor patient outcomes. The findings are: R #55A. Record review of R #55's admission record revealed R #55 was admitted to the facility on [DATE] with the following diagnoses:1. End stage renal disease (ESRD; chronic irreversible kidney failure),2. Adult failure to thrive (a rapid or gradual, unexplained, and severe decline in physical and/or cognitive function, typically in older adults),3. Anxiety disorder (mental health conditions characterized by persistent, excessive, and uncontrollable fear or worry that interferes with daily life),4. Depression (a mood disorder that causes a persistent feeling of sadness and loss of interest),5. Opioid dependence (state of adaptation that occurs with regular, long-term use of opioid drugs). B. Record review of R #55's physician's orders revealed an order dated 07/09/25 for Melatonin, five milligrams (mg) to be given by mouth one time a day for insomnia. C. On 02/26/26 at 2:54 pm, during an interview with the Director of Nursing (DON), she confirmed the following:1. R #55's indicated use of Melatonin is insomnia,2. R #55 does not have a diagnosis for insomnia,3. Medications should be documented to treat specific conditions as diagnosed and this was not. R#60 D. Record review of R #60's admission record revealed R #60 was admitted to the facility on [DATE] with the following diagnoses:1. Schizophrenia (a disorder that affects an individual's ability to think, feel, and behave clearly),2. Bipolar disorder (a disorder associated with episodes of mood swings ranging from depressive lows to manic highs),3. Bacteremia (presence of bacteria and infectious organisms in the blood stream),4. Syphilis (a sexually transmitted infection [STI]), 5. Pseudomonas (bacteria that occurs in soil or waste),6. Resistant to multiple antibiotics (MDR; occurs when bacteria or fungi evolve to withstand multiple drug treatments),7. Burn of third degree (destroys both the outer epidermis and the underlying dermis) of left lower limb,8. Cannabis (marijuana) use,9. Stimulant (a class of drugs that speed up messages travelling between the brain and body) use,10. Psychoactive substance use (consumption of substances that alter brain function, affecting mood, perception, consciousness, and behavior). E. Record review of R #60's physician's orders revealed an order dated 02/17/26 for Melatonin (a supplement), five milligrams (mg) to be given by mouth at bedtime for Insomnia (a common sleep disorder). F. On 02/26/26 at 2:54 pm, during an interview with the DON, she confirmed the following:1. R #60's indicated use of Melatonin is insomnia,2. R #60 does not have a diagnosis for insomnia,3. Medications should be documented to treat specific conditions as diagnosed and this was not.</p>		

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<p>F 0655</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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 3 (R #18, R #47, and R #60) of 6 (R #1, R #2, R #18, R #26, R #47, and R #60) residents reviewed for baseline care plans. 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: R #18</p> <p>A. Record review of R #18's admission record revealed R #18 was admitted into the facility on [DATE] with the following diagnoses:</p> <ol style="list-style-type: none"> 1. Chronic obstructive pulmonary disease (COPD; lung disease), 2. Cirrhosis (chronic liver damage leading to scarring and liver failure) of the liver, 3. Critical illness myopathy (diseases that cause weakness, pain, or stiffness in the muscles), 4. Permanent atrial fibrillation (abnormal heartbeat despite previous attempts to restore normal heart rhythm), 5. Nicotine dependence (uses tobacco). <p>B. On 02/22/26 at 2:28 pm during an observation R #18, she removed her upper denture (removeable plate or frame holding artificial teeth), and it was observed that her lower teeth are missing, broken or have cavities (a hole or empty space in a tooth).</p> <p>C. Record review of R #18's baseline care plan dated 10/24/25 revealed R #18 her has own teeth and dentures were not indicated.</p> <p>D. On 02/26/26 at 2:48 pm, during an interview with Director of Nursing (DON), she indicated that R #18's upper denture and other dental issues should have been indicated on the baseline care plan.</p> <p>E. Record review of R #60's admission record revealed R #60 was admitted to the facility on [DATE] with the following diagnoses:</p> <ol style="list-style-type: none"> 1. Schizophrenia (a disorder that affects an individual's ability to think, feel, and behave clearly), 2. Bipolar disorder (a disorder associated with episodes of mood swings ranging from depressive lows to manic highs), 3. Bacteremia (presence of bacteria and infectious organisms in the blood stream), 4. Syphilis (a sexually transmitted infection [STI]), 5. Pseudomonas (bacteria that occurs in soil or waste), (continued on next page) 		

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<p>F 0655</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>6. Resistant to multiple antibiotics (MDR; occurs when bacteria or fungi evolve to withstand multiple drug treatments),</p> <p>7. Burn of third degree (destroys both the outer epidermis and the underlying dermis) of left lower limb,</p> <p>8. Cannabis (marijuana) use,</p> <p>9. Stimulant (a class of drugs that speed up messages travelling between the brain and body) use,</p> <p>10. Psychoactive substance use (consumption of substances that alter brain function, affecting mood, perception, consciousness, and behavior).</p> <p>F. Record review of R #60's baseline care plan dated 02/17/26 revealed:</p> <p>1. R #60 is partial weight bearing and requires two-person assist (assistance by two staff members).</p> <p>2. R #60 had multiple scabs and burns all over his body.</p> <p>3. No instructions or indications of wound/injury care were indicated in the care plan.</p> <p>4. R #60's frequency of pain was constant with a pain level of 5.</p> <p>5. No instructions or indications of pain or monitoring of pain were included in the care plan.</p> <p>6. R #60 is a risk for falls.</p> <p>7. No instructions or indications of R #60's risk for falls were included in the care plan.</p> <p>8. R #60 has an infection.</p> <p>9. No instructions or indications of R #60's infection were included in the care plan,</p> <p>10. R #60 has orders for anti-psychotic medication.</p> <p>11. No instructions or indications of R #60's use of anti-psychotic medications were included in the care plan.</p> <p>G. Record review of R #60's physician orders revealed an order dated 02/17/26 for Olanzapine (anti-psychotic medication), five milligrams (mg) to be given by mouth in the morning for schizophrenia.</p> <p>H. On 02/23/26 at 9:58 am during an interview with the Infection Control Nurse (ICN) she confirmed:</p> <p>1. R #60 was admitted into the facility with Morganii (gram-negative rod bacterium) and Carbapenem-resistant Acinetobacter baumannii (CRAB; a type of bacteria that is resistant to many antibiotics),</p> <p>2. R #60 has an open wound, (continued on next page)</p>		

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<p>F 0655</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>3. R #60 is on transmission-based precautions (used to prevent the spread of infectious agents from individuals who are suspected to be infected. Includes contact precautions, droplet precautions, and airborne precautions. Examples are wearing gloves, face masks, and gowns or using disposable equipment).</p> <p>I. On 02/26/26 at 2:54 pm, during an interview with the Director of Nursing (DON), she confirmed the baseline care plan does not include minimum healthcare information necessary to properly care for R #60 and this does not meet her expectations.</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed to ensure staff revised the care plan for 3 (R #4 and R #7) of 4 (R #4, R #7, R #26, and R #55) residents reviewed when staff failed to:1. Revise R #4's care plan to:-Include use of a camera in R #4's room,-Include appropriate interventions for falls,-Include the changes in R #4's diet,-Remove the use of oxygen therapy,2. Revise R #7's care plan to remove the use of insulin therapy.These deficient practices are likely to result in residents' care and needs not being addressed if care plans are not updated. The findings are:R #4</p> <p>A. Record review of R #4's admission record revealed R #4 was admitted into the facility on [DATE].</p> <p>B. Record review of R #4's physician orders revealed:</p> <p>1. An order dated 02/16/26 for R #4 to be on a regular diet, pureed texture (a texture modified diet that requires no chewing), regular/thin consistency fluids.</p> <p>2. An order dated 02/14/26 for oxygen at two liters per minute (L/M) via nasal cannula (flexible tube with two prongs inserted into the nostrils to deliver supplemental oxygen) continuously with a humidified concentrator (a medical device that filters surrounding air to deliver oxygen) and portable tank (mobile containers designed for storing gases).</p> <p>3. An order dated 02/14/26 for oxygen at two liters via nasal canula continuous with approval to wean off (reduce or slowly discontinue) oxygen.</p> <p>C. Record review of R #4's progress notes revealed:</p> <p>1. On 11/14/25 R #4 had an unwitnessed fall,</p> <p>2. On 11/20/25 R #4 had a witnessed fall,</p> <p>3. On 12/04/25 R #4 had an unwitnessed fall,</p> <p>4. On 02/04/26 R #4 had an assisted fall.</p> <p>D. Record review of R #4's care plan, last revised on 01/23/26, revealed the following:</p> <p>1. No goals, instructions, or indications of care for the use of camera in R #4's room,</p> <p>2. There were no revisions to include interventions for falls that occurred on 11/14/25, 11/20/25, 12/04/26, and 02/04/26.</p> <p>3. R #4 is on a regular diet, mechanical soft texture (a texture modified diet that requires some chewing but less than a regular diet) and regular/thin liquid consistency.</p> <p>4. R #4 has oxygen therapy due to sleep apnea.</p> <p>E. On 02/22/26 at 2:26 pm a random observation of R #4's room, revealed: (continued on next page)</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>1. A device that appeared to be a camera above R #4's bed facing towards R #4 as he lay asleep in bed.</p> <p>2. R #4 was not wearing oxygen and there was not a concentrator in his room.</p> <p>F. On 02/26/26 at 2:54 pm during an interview with the Director of Nursing (DON) she confirmed the following:</p> <p>1. R #4 has a camera in his room that is used to monitor seizure activity when R #4 is lying in bed. She stated staff are instructed to reposition the camera away or turn off the camera during care to ensure privacy.</p> <p>2. The use of the camera should be included in the care plan, and it is not.</p> <p>3. R #4's care plan for fall risk interventions does not include interventions for falls that occurred after 11/05/25.</p> <p>4. The diet texture listed in R #4's care plan is incorrect; it should state that R #4 is on a puree diet.</p> <p>5. R #4 is not on continuous oxygen; the care plan should have been revised to remove continuous oxygen, and it was not.</p> <p>R #7</p> <p>G. Record review of R #7's admission record revealed she was admitted into the facility on [DATE] with the following diagnoses:</p> <p>1. Insomnia (a common sleep disorder making it hard to fall asleep, stay asleep),</p> <p>2. Depression (a mental health disorder characterized by persistently depressed mood or loss of interest in activities, causing significant impairment in daily life),</p> <p>3. Bipolar disorder (a disorder associated with episodes of mood swings ranging from depressive lows to manic highs),</p> <p>4. Generalized anxiety disorder (an overall feeling of fear or apprehension),</p> <p>5. Type 2 Diabetes mellitus with unspecified complications (DM2, a condition that results from insufficient production of insulin, causing high blood sugar).</p> <p>H. Record review of R #7's physician record revealed an order for Insulin Glargine (a medication used to control blood sugar levels) fifteen units subcutaneously (under the skin) every day for (DM2) that was discontinued on 10/21/25.</p> <p>I. Record review of R #7's care plan, revised on 05/22/25 revealed an intervention to inject Insulin Glargine.</p>

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<p>F 0732</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Post nurse staffing information every day.</p> <p>Based on observation and interview, the facility failed to post nurse staffing data daily at the beginning of the shift that included 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.The deficient practice has the potential to affect all 51 residents as identified by the census provided by the Manager on Duty (MOD) on 02/22/26 and could likely result in residents and visitors not having the staffing information readily available. The findings are:A. On 02/22/26 at 9:30 am a random observation of the facility revealed the facility's staff data posting was dated 02/21/26.B. On 02/22/26 at 9:40 am, during an interview with the MOD, she confirmed the staff data posting was for 02/21/26 and had not been updated daily.</p>		

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<p>F 0757</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure each resident's drug regimen must be free from unnecessary drugs.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure each resident's drug regimen (plan to manage a person's medication) was free from unnecessary drugs by ensuring indication of use is based on the residents' current diagnosis for 8 (R #1, R #4, R #7, R #9, R #46, R #55, R #60, and R # 63) of 9 (R #1, R #4, R #6, R #7, R #9, R #46, R #55, R #60, and R #63) residents reviewed for unnecessary medication. This deficient practice could likely lead to adverse drug effects and poor patient outcomes. The findings are: R #1</p> <p>A. Record review of R #1's admission record revealed R #55 was admitted into the facility on [DATE] with the following diagnoses:</p> <ol style="list-style-type: none"> 1. Hypertension (HTN; high blood pressure), 2. Hypoglycemia (low blood sugar), 3. Localized edema (the swelling of a specific body area), 4. Psychoactive substance use (consumption of substances that alter brain function, affecting mood, perception, consciousness, and behavior). <p>B. Record review of R #1's physician orders revealed an order dated 02/18/26 for Ropinirole Hydrochloride (a dopamine agonist medication) oral tablet one milligram (MG) to be given by mouth one time a day for restless leg syndrome (RLS; a common neurological disorder causing an irresistible urge to move legs).</p> <p>C. On 02/26/26 at 2:54 pm, during an interview with the Director of Nursing (DON), she confirmed the following:</p> <ol style="list-style-type: none"> 1. R #1's indicated use of Ropinirole Hydrochloride is RLS, 2. R #1 does not have a diagnosis for RLS, 3. Medications should be documented to treat specific conditions as diagnosed and this was not. <p>R #46</p> <p>D. Record review of R #46's admission record revealed R #46 was admitted into the facility on [DATE] with the following diagnoses:</p> <ol style="list-style-type: none"> 1. Type 2 Diabetes Mellitus (DM2, a condition that results from insufficient production of insulin, causing high blood sugar), 2. Depression (a mood disorder that causes a persistent feeling of sadness and loss of interest), 3. Hyperlipidemia (a condition in which there are high levels of fat particles in the blood; high cholesterol), <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER Artesia Healthcare & Rehabilitation Center, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 1402 West Gilchrist Ave Artesia, NM 88210	
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<p>F 0757</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>4. Hypercholesterolemia (dangerously high levels of LDL (bad) cholesterol),</p> <p>5. Insomnia (sleep disorder that can make it hard to fall asleep or stay asleep),</p> <p>6. Hypertension (HTN; high blood pressure),</p> <p>7. Chronic kidney disease (CKD; impaired kidney function).</p> <p>E. Record review of R #46's physician's orders revealed the following:</p> <p>1. An order dated 06/06/23 for Allopurinol (anti-inflammatory medication) oral tablet, 200 MG to be given by mouth one time a day for GOUT.</p> <p>2. An order dated 12/21/23 for Keppra (anti-convulsant medication) oral tablet, 750 MG to be given by mouth two times a day for seizures.</p> <p>F. On 02/26/26 at 2:54 pm, during an interview with the DON, she confirmed the following:</p> <p>1. R #46's indicated use of Allopurinol is gout,</p> <p>2. R #46 does not have a diagnosis for gout,</p> <p>3. R #46's indicated use of Keppra is seizures,</p> <p>4. R #46 does not have a diagnosis for seizures,</p> <p>5. Medications should be documented to treat specific conditions as diagnosed and these were not.</p> <p>R #55</p> <p>G. Record review of R #55's admission record revealed R #55 was admitted into the facility on [DATE] with the following diagnoses:</p> <p>1. End stage renal disease (ESRD; chronic irreversible kidney failure),</p> <p>2. Adult failure to thrive (a rapid or gradual, unexplained, and severe decline in physical and/or cognitive function, typically in older adults),</p> <p>3. Anxiety disorder (mental health conditions characterized by persistent, excessive, and uncontrollable fear or worry that interferes with daily life),</p> <p>4. Depression (a mood disorder that causes a persistent feeling of sadness and loss of interest),</p> <p>5. Opioid dependence (state of adaptation that occurs with regular, long-term use of opioid drugs),</p> <p>H. Record review of R #55's physician's orders revealed the following:</p> <p>1. An order dated 11/01/25 for Gabapentin capsule (anti-convulsant medication), 300 MG to be given by mouth three times a day for neuropathy pain. (continued on next page)</p>		

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<p>F 0757</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>2. An order dated 01/15/26 for Torsemide (diuretic; water pill) oral tablet twenty MG to be given by mouth one time a day for Diuretic therapy. Start Date-01/15/26</p> <p>1. On 02/26/26 at 2:54 pm, during an interview with the DON, she confirmed the following:</p> <p>1. R #55's indicated use of Gabapentin is neuropathy pain,</p> <p>2. R #55 does not have a diagnosis for neuropathy,</p> <p>3. R #55's indicated use of Torsemide is diuretic therapy.</p> <p>3 Diuretic therapy is not an appropriate indication of use for medication and does not meet her expectations.</p> <p>4. Medications should be documented to treat specific conditions as diagnosed and these were not.</p> <p>R#60</p> <p>J. Record review of R #60's admission record revealed R #60 was admitted into the facility on [DATE] with the following diagnoses:</p> <p>1. Schizophrenia (a disorder that affects an individual's ability to think, feel, and behave clearly),</p> <p>2. Bipolar disorder (a disorder associated with episodes of mood swings ranging from depressive lows to manic highs),</p> <p>3. Bacteremia (presence of bacteria and infectious organisms in the blood stream),</p> <p>4. Syphilis (a sexually transmitted infection [STI]),</p> <p>5. Pseudomonas (bacteria that occurs in soil or waste),</p> <p>6. Resistant to multiple antibiotics (MDR; occurs when bacteria or fungi evolve to withstand multiple drug treatments),</p> <p>7. Burn of third degree (destroys both the outer epidermis and the underlying dermis) of left lower limb,</p> <p>8. Cannabis (marijuana) use,</p> <p>9. Stimulant (a class of drugs that speed up messages travelling between the brain and body) use,</p> <p>10. Psychoactive substance use (consumption of substances that alter brain function, affecting mood, perception, consciousness, and behavior).</p> <p>K. Record review of R #60's physician's orders revealed the following:</p> <p>1. An order dated 02/17/26 for Suboxone (a dual medication [buprenorphine; pain management medication and naloxone; medication used to reverse opioid overdose] used to reduce craving and (continued on next page)</p>		

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<p>F 0757</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>withdrawal symptoms such as pain, from opioid [pain killer medications] dependance) sublingual film (thin dissolvable strip absorbed under the tongue) 8-2 milligrams MG to be given three times a day for opioid use disorder.</p> <p>2. An order dated 02/17/26 for Methocarbamol (muscle relaxer medication) oral tablet 500 MG to be given by mouth four times a day for muscle relaxer.</p> <p>3. An order dated 02/17/26 for Benztropine Mesylate (anticholinergic agent; use to treat involuntary movements) oral tablet 0.5 MG to be given by mouth at bedtime for muscle stiffness/tremors.</p> <p>L. On 02/26/26 at 2:54 pm, during an interview with the DON, she confirmed the following:</p> <p>1. R #60's indicated use of suboxone is opioid disorder,</p> <p>2. R #60 does not have a diagnosis for opioid disorder,</p> <p>3. R #60's indicated use of Methocarbamol is muscle relaxer.</p> <p>3 Muscle relaxer is not an appropriate indication of use for medication and does not meet her expectations.</p> <p>4. R #60's indicated use of Benztropine Mesylate is stiffness/tremors.</p> <p>5. R #60 does not have a diagnosis for stiffness/tremors.</p> <p>6. Medications should be documented to treat specific conditions as diagnosed and these were not.</p> <p>R #7</p> <p>M. Record review of R #7's admission record revealed she was admitted into the facility on [DATE] with the following diagnoses:</p> <p>1. Insomnia (a common sleep disorder making it hard to fall asleep, stay asleep),</p> <p>2. Depression, unspecified (a mental health disorder characterized by persistently depressed mood or loss of interest in activities, causing significant impairment in daily life),</p> <p>3. Bipolar disorder, unspecified (a disorder associated with episodes of mood swings ranging from depressive lows to manic highs),</p> <p>4. Generalized anxiety disorder (an overall feeling of fear or apprehension).</p> <p>N. Record review of R #7's physician orders revealed an order dated 12/08/25 for Risperidone (anti-psychotic medication) oral tablet 0.25 MG to be given once daily for aggressive behaviors.</p> <p>O. On 02/26/26 at 2:54 pm, during an interview with the DON, she confirmed that R #7 does not have a diagnosis of aggressive behaviors.</p> <p>R #9 (continued on next page)</p>		

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<p>F 0757</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>P. Record review of R #9's admission record revealed she was admitted into the facility on [DATE] with the following diagnoses:</p> <ol style="list-style-type: none"> 1. Dementia with other behavior disturbance (a group of conditions characterized by impairment of at least two brain functions, such as memory loss and judgment that affect behaviors), 2. Major depressive disorder (a mental health disorder characterized by persistently depressed mood or loss of interest in activities, causing significant impairment in daily life), 3. Need for assistance with personal care (requirement for help with daily activities that individuals may need help with). <p>Q. Record review of R #9's physician orders revealed the following:</p> <ol style="list-style-type: none"> 1. An order dated 03/31/23 for Melatonin oral capsule three MG to be given by mouth at bedtime for agitation. 2. An order dated 11/27/24 for Risperidone tablet one MG to be given by mouth daily for unspecified dementia. <p>R. Record review of R #9's monthly Medication Administration Record (MAR) for February 2026 revealed:</p> <ol style="list-style-type: none"> 1. R #9 was administered Melatonin nightly from 02/01/26-02/25/26. 2. R #9 was administered Risperidone once daily from 02/01/26-02-05-26. 3. R #9 was not being monitored for side effects of the risperidone (antipsychotic medication). 4. R #9 was not being monitored for number of hours of sleep at night to warrant the continued use of the melatonin. <p>S. On 02/26/26 at 3:00 pm, during an interview with the DON, she confirmed the following:</p> <ol style="list-style-type: none"> 2. R #9 has an active order for risperidone and does not have an order for monitoring for side effects for this medication. 3. The indication of use for R #9's use of Melatonin is agitation but R #9 does not have a diagnosis of agitation and agitation is not an appropriate indication of use. 4. R #9 does not have a diagnosis of insomnia. <p>R #63</p> <p>T. Record review of R #63's admission record revealed he was admitted into the facility on [DATE] with the following diagnoses:</p> <ol style="list-style-type: none"> 1. Gangrene (a medical emergency in which blood stops flowing to specific parts of the body, and tissues in that area die), (continued on next page) 		

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<p>F 0757</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>2. Frostbite with tissue necrosis of right fingers, left fingers, right toes, and left toes (an injury caused by freezing of the skin and underlying tissues, resulting in damage to the skin and deeper tissues),</p> <p>3. Need for assistance with personal care (requirement for help with daily activities that individuals may need help with),</p> <p>4. Schizophrenia (a disorder that affects an individual's ability to think, feel, and behave clearly).</p> <p>U. Record review of R #63's physician orders revealed the following:</p> <p>1. An order dated 02/18/26 for Sertraline (HCl) oral tablet fifty MG to be given by mouth once daily for depression.</p> <p>2. An order dated 02/21/26 for Olanzapine fifteen MG oral tablet to be given by mouth once daily for schizophrenia.</p> <p>3. An order dated 02/22/26 for behavior monitoring due to antidepressant use.</p> <p>4. An order dated 02/22/26 for anti-psychotic medication-monitoring for side effects of medication as needed.</p> <p>V. Record review of R #63's MAR dated February 2026 revealed:</p> <p>1. Resident #63 was administered Sertraline daily from 02/18/26-02/25/26.</p> <p>2. Resident #63 was administered Olanzapine daily from 02/18/26-02/25/26.</p> <p>3. Resident #63 was not monitored for side effects of an antidepressant while on Sertraline from 02/18/26-02/25/26.</p> <p>4. Resident #63 was not monitored for psychotic behaviors while on Olanzapine from 02/18/26-02/25/26.</p> <p>W. On 02/26/26 at 3:00 pm during an interview with the DON, she confirmed R #63 does not have behavior monitoring for the antipsychotic medication olanzapine and does not have side effect monitoring for the antidepressant medication he takes. R #63's medication regimen and monitoring of psychotropic medications does not meet her expectations, because psychotropic medications should be monitored for behaviors and side effects while the residents are taking these medications.</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>Based on observation and interview, the facility failed to ensure food was prepared and served under sanitary conditions when staff failed to ensure:1. Staff wore hairnets and beard nets while in the kitchen. 2. Food items were labeled and dated. These deficient practices are likely to affect all 51 residents listed on the resident census list provided by the Administrator on 02/22/26 and are likely to lead to foodborne illnesses in residents if safe food handling practices are not adhered to and food stored properly. The findings are:A. On 02/22/26 at 9:46 am, an observation of the kitchen revealed Dietary Aid (DA) #1 not wearing a beard net (a type of hair net used for facial hair).B. On 02/22/26 at 9:48 am during an interview with Dietary Assistant Manager (DAM), she confirmed that DA #1 was not properly wearing a beard net. She stated her expectation is for all staff to properly wear hairnets and beard nets while in the kitchen or serving food.C. On 02/22/26 at 9:51 am, an observation of the kitchen revealed the following:1. A bag of what appeared to be Tator tots that was not labeled or dated2. A bag of what appeared to be meatballs that was not labeled or dated3. A bag of what appeared to be French fries that was not labeled or dated.D. On 02/22/26 at 9:57 am, during an interview with the Dietary Aide (DA) #1, he confirmed the items in the freezer were not labeled and dated. He confirmed the items in the freezer should be labeled and dated.</p>		

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<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>

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<p>F 0645</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>PASARR screening for Mental disorders or Intellectual Disabilities</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure the PASARR (Preadmission Screening and Resident Review) Level I Identification Screen accurately reflected the resident's diagnosis or need for secondary screening for 2 (R #26 and R #31) of 5 (R #18, R #26, R #31, R #45, and R #55) residents reviewed for accuracy of PASARR screening. If the facility does not ensure PASARR screenings are completed accurately, then residents with serious mental illness may not receive required evaluations or specialized services, placing them at risk for unmet mental health needs and a decline in psychosocial well-being. The findings are: R #26A. Record review of R #26's face sheet indicated that R #26 was admitted to the facility on [DATE] with the following medical diagnoses: 1. Hemiplegia (paralysis of the arm, leg, and trunk on the same side of the body) and hemiparesis (partial weakness, reduced muscle strength, or impaired motor control affecting one entire side of the body) following cerebral infarct (stroke) affecting right dominant side, 2. Type II diabetes (DM2, a condition results from insufficient production of insulin, causing high blood sugar), 3. Depression (a mood disorder that causes a persistent feeling of sadness and loss of interest), 4. Mixed anxiety (feelings of fear or apprehension) and depression. B. Record review of R #26's PASARR form dated 06/20/25 revealed a PASARR level II was required. C. On 02/26/26 at 3:29 pm, during an interview with the Director of Nursing (DON), she stated that the PASRR section E, should not have indicated the need for PASRR 2 evaluation and the form was not filled out correctly. The DON stated that this form does not meet her expectations because it is incorrect. R #31D. Record review of R #31's face sheet indicated that R #31 was admitted to the facility on [DATE] with the following medical diagnoses: 1. Schizophrenia (a disorder that affects an individual's ability to think, feel, and behave clearly), 2. Psychoactive substance abuse (non-medical use of substances that alter brain function, resulting in significant physical, social or psychological harm), 3. Post-traumatic stress disorder (PTSD; a mental health condition triggered by a terrifying event, causing flashbacks, nightmares, and severe anxiety). E. Record review of PASRR dated 12/29/25 section E indicated R #31 had no mental health illnesses issues. F. On 02/26/26 at 3:29 pm, during an interview with the DON, she stated that the PASRR should have indicated the schizophrenia diagnoses in this section and it does not. The DON stated this did not meet her expectations because it is incorrect.</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed to develop and implement an accurate, comprehensive care plan for 1 (R #4) of 4 (R #1, R #2, R #4, and R #26) residents reviewed for care plans when staff failed to implement R #4's care plan for falls by utilizing the fall mat. This deficient practice could likely result in proper care not being provided to residents. The findings are: A. Record review of R #4's admission record revealed R #4 was admitted into the facility on [DATE]. B. Record review of R #4's care plan, last revised on 03/31/25, revealed an intervention to offer fall mat as indicated. C. On 02/22/26 at 2:26 pm, a random observation of R #4's room, revealed R #4 was lying in bed and the fall mat was located underneath his bed. D. On 02/22/26 at 2:37 pm, during an interview with Registered Nurse (RN) #2 she confirmed R #4's fall mat was not placed correctly, and that it should be placed on the floor next to his bed. E. On 02/26/26 at 2:54 pm during an interview with the Director of Nursing (DON) she confirmed the recommended use of R #4's fall mat was to be placed on the floor next to his bed when he is lying in his bed. She confirmed the care plan is not person centered and should indicate what the specific recommendations are.</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure services provided by the nursing facility meet professional standards of quality.</p> <p>Based on observation, record review, and interview, the facility failed to provide quality care that meets professional standards for 1 (R #42) of 1 (R #42) resident reviewed when the staff failed to follow physician orders. This deficient practice is likely to result in residents not maintaining their optimal health as planned by their medical provider. The findings are: Cross Reference 760A. Record review of R #42's physician's orders revealed an order dated 10/24/25 for Losartan (angiotensin(hormone) receptor blocker to treat high blood pressure) 25 milligrams (mg), give half tablet by mouth one time a day for hypertension. Notify MD (Medical Doctor) for hold orders if SBP (systolic (top number of blood pressure) blood pressure) less than 110 or DBP (diastolic (bottom number) blood pressure) less than 60 or pulse less than 60. B. On 02/25/26 at 8:54 am, during an observation of medication administration, Licensed Practical Nurse (LPN) #2 reported a blood pressure reading of 103/61. She then administered the medication outside the prescribed parameters. C. On 02/26/26 at 3:45 pm, during an interview with the Director of Nursing (DON), she stated that staff who are passing medications should follow orders as written, this does not meet her expectations for medication administration.</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident?s preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, and interview, the facility failed to provide quality of care when staff failed to implement and follow discharge orders for wound care for 1 (R #60) of 3 (R #1, R #4, and R #60) resident reviewed. These deficient practices could likely result in residents to not getting the treatment needed and/or potentially worsening conditions. The findings are:A. Record review of R #60's admission record revealed R #60 was admitted into the facility on [DATE] with the following diagnoses:1. Schizophrenia (a disorder that affects an individual's ability to think, feel, and behave clearly),2. Bipolar disorder (a disorder associated with episodes of mood swings ranging from depressive lows to manic highs),3. Bacteremia (presence of bacteria and infectious organisms in the blood stream),4. Syphilis (a sexually transmitted infection [STI]), 5. Pseudomonas (bacteria that occurs in soil or waste),6. Resistant to multiple antibiotics (MDR; occurs when bacteria or fungi evolve to withstand multiple drug treatments),7. Burn of third degree (destroys both the outer epidermis and the underlying dermis) of left lower limb,8. Cannabis (marijuana) use,9. Stimulant (a class of drugs that speed up messages travelling between the brain and body) use,10. Psychoactive substance use (consumption of substances that alter brain function, affecting mood, perception, consciousness, and behavior).B. Record review of R #60's hospital discharge order dated 02/16/26 revealed the following wound care instructions: 1. Change dressing to right hand and both legs every 5-7 days. Cleanse with soap and water, pat dry and apply mepilex ag dressing (a soft, conformable antimicrobial foam dressing with silver, designed to manage low-to-moderately exuding wounds-such as burns, pressure ulcers, and surgical wounds-while minimizing pain and trauma upon removal), secure with kerlix (sterile gauze) or tape.2. Apply moisturizer four times a day to face, left hand, healed areas on both legs.C. Record review of R #60's electronic health record revealed there were no physician orders for wound care or moisturizer.D. Record review of R #60's baseline care plan dated 02/17/26 revealed R #60 had multiple scabs and burns all over his body. No instructions or interventions were included in the care plan for how to care for R #60's wounds and injuries.E. On 02/23/26 at 9:58 am during an interview with the infection control nurse (ICN) she confirmed that R #60 has an open wound. She stated she applied gauze covering to the wound on his right leg because the wound was sticking to his pants.F. On 02/26/26 at 2:54 pm, during an interview with the Director of Nursing (DON), she confirmed R #60 does not have orders and care plan interventions for wound care treatment and should. R #60 came to facility with wound care instructions. They were not followed and were not implemented. This practice did not meet her expectations.</p>		

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 0697</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe, appropriate pain management for a resident who requires such services.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to effectively manage pain (use of different techniques and medication to reduce and control the amount of pain a person experiences) for 1 (R #60) of 2 (R #1 and R #60) residents reviewed for pain when the facility failed to:1. Administer medications as per physician's orders.2. Monitor pain.3. Implement a care plan and interventions for pain management.This deficient practice could likely result in residents experiencing unnecessary pain and could compromise their quality of life. The findings are: A. Record review of R #60's admission record revealed R #60 was admitted into the facility on [DATE] with the following diagnoses:1. Schizophrenia (a disorder that affects an individual's ability to think, feel, and behave clearly),2. Bipolar disorder (a disorder associated with episodes of mood swings ranging from depressive lows to manic highs),3. Bacteremia (presence of bacteria and infectious organisms in the blood stream),4. Syphilis (a sexually transmitted infection [STI]), 5. Pseudomonas (bacteria that occurs in soil or waste),6. Resistant to multiple antibiotics (MDR; occurs when bacteria or fungi evolve to withstand multiple drug treatments),7. Burn of third degree (destroys both the outer epidermis and the underlying dermis) of left lower limb,8. Cannabis (marijuana) use,9. Stimulant (a class of drugs that speed up messages travelling between the brain and body) use,10. Psychoactive substance use (consumption of substances that alter brain function, affecting mood, perception, consciousness, and behavior).B. Record review of R #60's physician's orders revealed the following:1. An order dated 02/17/26 for Suboxone (a dual medication [buprenorphine; pain management medication and naloxone; medication used to reverse opioid overdose] used to reduce craving and withdrawal symptoms such as pain, from opioid [pain killer medications] dependence) Sublingual film (thin dissolvable strip absorbed under the tongue) 8-2 milligrams (MG). Give one sublingually three times a day for opioid use disorder.2. An order dated 02/17/26 for Oxycodone Hydrochloride (pain medication) oral tablet fifteen milligrams (MG) to be given by mouth every four hours as needed for moderate pain.3. An order dated 02/17/26 for Tylenol (pain medication) Oral Tablet 325 milligrams (MG). Give two tablets by mouth every six hours as needed for pain or fever.4. No order for monitoring of pain.C. Record review of R #60's Medication Administration Record (MAR; a tool used to document the daily administration of medications) dated February 2026 revealed:1. R #60 did not receive suboxone on 02/17/26, 02/18/26, 02/19/26, and 02/20/26; approximately four days due to medication not available.2. R #60 has not been administered Oxycodone.3. R #60 has not been administered Tylenol.4. There is no documented pain level.D. Record review of R #60's baseline care plan dated 02/17/26 revealed R #60's frequency of pain was constant with a pain level of five (moderate pain). No instructions or indications of pain was included in the care plan.E. On 02/25/26 at 2:42 pm, during an interview with R #60, he stated his pain is usually at a ten (worst pain imaginable on a pain scale of 0-10).F. On 02/26/26 at 2:54 pm, during an interview with the Director of Nursing (DON), she confirmed:1. R #60 did not receive his suboxone medications as ordered due to the medication not being available in the facility.2. R #60 did not receive Oxycodone or Tylenol during the days suboxone was not available.3. R #60's pain level was not monitored during the days that the suboxone medication was not available because pain monitoring has not been done for this resident. 4. R #60 does not have pain monitoring and should.5. R #60 does not have care plan that includes instructions and interventions for pain management and he should.</p>		

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NAME OF PROVIDER OR SUPPLIER Artesia Healthcare & Rehabilitation Center, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 1402 West Gilchrist Ave Artesia, NM 88210	

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<p>F 0700</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed to obtain appropriate physician orders prior to installation of bed rails for 1 (R #60) of 2 (R #46 and R #60) residents reviewed for bedrails. This deficient practice could result in the physician and the resident not knowing the needs, risks and benefit of bed rails. The findings are:A. Record review of R #60's admission record revealed R #60 was admitted into the facility on [DATE]. B. Record review of R #60's physician orders revealed no order for the use of bedrails.C. Record review of R #60's bedrail assessment dated [DATE] revealed R #60 does use bedrails to enhance mobility. D. On 02/23/26 at 8:38 am during a random observation of R #60's room revealed quarter size bedrails on the upper right and left sides of bed. E. On 02/23/26 at 8:42 pm during an interview with R #60, he confirmed he uses the bedrails for mobility and repositioning himself. F. On 02/26/26 at 2:54 pm, during an interview with the Director of Nursing (DON), she confirmed the R #60 does not have physician orders for use of bed rails and should prior to installation.</p>

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NAME OF PROVIDER OR SUPPLIER Artesia Healthcare & Rehabilitation Center, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 1402 West Gilchrist Ave Artesia, NM 88210	

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that residents are free from significant medication errors.</p> <p>Based on record review and interview, the facility failed to ensure residents were free of any significant medication errors for 1 (R #42) of 1 (R #42) residents reviewed for medication administration when they failed to administer medication per physician's orders. This deficient practice could likely lead to the residents having adverse (unwanted, harmful, or abnormal result) side effects or not receiving the desired therapeutic effect of the medication. The findings are:A. Record review of R #42's Physician's orders revealed an order dated 10/24/25 for Losartan (angiotensin(hormone) receptor blocker to treat high blood pressure) 25 milligrams (mg); Give 0.5 tablet by mouth one time a day for hypertension. Notify MD (Medical Doctor) for hold orders if SBP (systolic (top number of blood pressure) blood pressure) less than 110 or DBP (diastolic (bottom number) blood pressure) less than 60 or pulse less than 60.B. Record review of R #42's Medication Administration Record (MAR) for February 2026, revealed staff administered the following:-Losartan, 0.5 (or 1/2) of 25 mg, 02/02/26, 02/07/26, 02/15/26, 02/21/26, 02/25/26 outside of the given parameters.C. Record review of R #42's blood pressures documented prior to administration of Losartan revealed:1. 02/02/26 - 108/602. 02/07/26 - 108/723. 02/15/26 - 100/654. 02/21/26 - 107/725. 02/25/26 - 103/61D. On 02/26/26 at 3:40 pm, during an interview with the Director of Nursing (DON), she stated the following: 1. R #42 received her blood pressure medication outside the prescribed parameters. 2. The medication was administered outside the prescribed parameters causing a significant medication error. 3. She stated her expectations are for the nurses to follow the orders as written, hold the medication and call the doctor to verify parameters.</p>

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<p>F 0849</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure hospice services met professional standards for 1 (R #4) of 1 (R #4) residents reviewed for hospice services by:1. Not having a qualifying diagnosis for R #4.2. Not having hospice plans of care for R #4. These deficient practices are likely to result in the resident not receiving the services that she needs. The findings are:A. Record review of R #4's admission record revealed R #4 was originally admitted to the facility on [DATE] and re-admitted on [DATE] with the following diagnosis:1. Alzheimer's disease (a progressive brain disorder that damages and destroys nerve cells leading to a decline in abilities and behavioral changes),2. Dementia (a group of conditions characterized by impairment of at least two brain functions, such as memory loss and judgment),3. Epilepsy (a seizure disorder),4. Down Syndrome (a genetic condition),B. Record review of R #4's hospice admission order form (a form completed by a hospice nurse to identify diagnosis, activity, diet, allergies and medication orders), revealed:1. R #4 was admitted to hospice on 11/06/25.2. R #4 was admitted to hospice care with a diagnosis listed as Down Syndrome.C. Record review of R #4's Electronic Health Record (EHR) revealed the hospice plan of care was not available. D. On 02/26/25 at 2:54 pm, during an interview with the Director of Nursing (DON), she confirmed the following:1. R #4 is currently receiving hospice services.2. R #4's current hospice admission order form dated 11/06/25, listed Down Syndrome diagnoses does not meet her expectations as a qualifying diagnosis for hospice care.3. The facility does not have a record of R #4's hospice plan of care.</p>

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NAME OF PROVIDER OR SUPPLIER Artesia Healthcare & Rehabilitation Center, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 1402 West Gilchrist Ave Artesia, NM 88210	

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>Based on observations and interviews, the facility failed to utilize enhanced barrier precautions (an infection control intervention) when providing personal care to 1 (R #10) of 2 (R #10 and R #23) residents. Failure to utilize enhanced barrier precautions when performing personal care has the potential to spread organisms, diseases, and other health conditions among the residents. The findings are: A. On 02/22/26 at 10:02 am, during a random observation of R #10's room, the door to her room revealed a sign on the door that indicated R #10 was on enhanced barrier precautions (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) when providing care for her.B. On 02/24/26 at 1:27 pm, during an observation and interview of R #10's tube feeding, Licensed Practical Nurse (LPN) #1 was observed accessing the feeding tube. LPN #1 wore gloves while accessing the tube but did not put on the required gown as per EBP signage on the door. LPN stated he is not required to wear a gown when accessing the feeding tube.C. On 02/24/26 at 1:35 pm during a second interview with LPN #1 he stated he reviewed the requirements on the EPB sign on the door and realized that he should have been wearing a gown.D. On 02/26/26 at 3:45 pm, during an interview with the Director of Nursing (DON), she stated that tube feedings require proper personal protective equipment and this did not meet her expectations.</p>