STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	325073	A. Building B. Wing	12/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Socorro Wellness & Rehabilitation	1203 Highway 60 West Socorro, NM 87801

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 - Minimal harm or potential for actual harm Residents Affected - Some	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 and interview, the facility failed to protect 25 out of 25 residents on the secure unit and North Hall (residents were identified by the resident census report, dated 10/18/24, provided by the Administrator on 12/13/24) sampled for abuse and neglect, when a staff member: 1. Abandoned residents by frequently leaving the building to go to his car multiple times throughout the shift. 2. Wore air pods (wireless headphones for listening to music and answering phone calls) in both ears, which prevented him from hearing what was occurring on the unit. 3. Fell asleep on the unit couch during the dinner meal. 4. Used loud, foul, abusive language. These deficient practices could result in residents' needs not being met, staff not being unaware of urgent resident needs, and residents feeling unsafe in their home. The findings are. A. Record review of the Incident Report, dated 10/25/24, revealed the following: 1. An abuse and neglect type of incident occurred on 10/19/24 at 6:00 PM. 2. CNA #1 was asleep on the job. 3. CNA #1 smelled of alcohol. 4. CNA #1 became belligerent, cussed at staff, and threatened to kill staff. 5. CNA #1 got into an RN's space and threatened to hit her. 6. The Incident Report was submitted to the State Agency on 10/25/24 at 4:59 PM. B. Record review of the Follow Up Report, dated 10/28/24, revealed the following: 1. Residents in the common area witnessed the yelling and cussing between CNA #1 and other staff. 2. The residents in the North Hall heard the yelling and cussing between CNA #1 and other staff. (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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(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 - Minimal harm or potential for actual harm Residents Affected - Some	C. On 12/11/24 at 12:40 PM, during an interview, RN #1 stated the following: 1. She was told to communicate any concerns she may have during her shift to the Scheduler, and the scheduler would notify the DON since the DON was out of town. 2. CNA #1 was scheduled to work on 10/18/24 in the secure unit 3. On 10/18/24 (inconsistent with date on incident report) CNA #1 came in late for his first shift as a traveling CNA. 4. CNA #1 did not help CNA #2 get residents up, change the residents' briefs, or provide showers for the residents in the secure unit. 5. CNA #1 wore his air pods throughout the shift. 6. CNA #1 frequently went to his car throughout his shift. 7. She notified the Scheduler multiple times about her concerns with CNA #1 not assisting CNA #2 with resident care, wearing his air pods, and going to his care frequently. 8. On 10/18/24 at 5:30 PM, all the residents were in the dining room, and CNA #1 was asleep on the couch. 9. On 10/18/24 at 5:30 PM, she woke CNA #1 up and told him that he needed to gather his belongings and leave the facility. 10. CNA #1 smelled like alcohol when she woke him up. 11. CNA #1 yelled profanities and threatened her. 12. CNA #1 continued to yell at her as he was escorted out of the building through the secure unit then down the North Hall. 13. She was nervous CNA #1 would hurt her or the residents. 14. CNA #1 lunged at her. 15. She felt nervous and threatened by CNA #1's behavior. 16. Police found alcohol bottles in CNA #1's car. 17. The Scheduler notified the DON about what occurred. D. On 12/11/24 at 1:58 PM, during an interview, the Scheduler stated the following: 1. She stated the DON was out of town on the weekend of 10/18/24, and staff were expected to communicate concerns to her (Scheduler). She stated she would handle what she could and notify the DON, if necessary. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. She was responsible for CNA scheduling. 3. She worked on 10/18/24 when CNA #1 worked. 4. CNA #1 worked for an outside agency. 5. CNA #1's first time working at the facility was on 10/18/24. 6. CNA #1 was an hour late for his shift. 7. She observed CNA #1 going out to his car multiple times throughout the shift. 8. RN #1 told her CNA #1 kept going out to his car, was on his phone, and sat around. 9. She told CNA #1 he could not keep going out to his car during his shift or be on his phone. 10. On 10/18/24 at 5:30 PM, CMA #1 sent her a picture of CNA #1 sleeping on the couch in the secure unit. 11. She told staff to send CNA #1 home. 12. CNA #1 became belligerent (hostile and aggressive) with staff when they woke him up. 13. Staff called the police due to CNA #1's behavior. 14. She went back to the facility on [DATE] when staff notified her that they called the police. 15. She notified the DON and the Administrator about the situation when she went back to the facility. E. On 12/11/24 at 3:18 PM, during an interview, CNA #3 stated the following: 1. On 10/28/24, he heard CNA #1 yelling and cussing while staff passed out dinner trays in the North Hall. 2. He saw CNA #1 get close to RN #1, and he looked like he was going to hit her. 3. RN #1 and another male staff member tried to get CNA #1 out of the building. 4. CNA #1 became aggressive toward the other male staff member. 5. He diffused the situation and walked CNA #1 out of the building. 6. CNA #1 went to the front of the building, but the door was locked. 7. Staff refused to let CNA #1 back in the building. 8. The police found alcohol in CNA #1's vehicle. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	F. On 12/11/24 at 3:29 PM, during an interview, CMA #1 stated the following: 1. On 10/18/24, CNA #2 told her that CNA #1 was not providing resident care. 2. She assisted CNA #2 with passing out lunch trays and other resident care, because CNA #1 was not helping. 3. She notified the Scheduler that CNA #1 took a lot of breaks. 4. The Scheduler said for staff to get through that shift, and they would not allow CNA #1 to come back to the facility. 5. On 10/28/24 at 5:30 PM, the residents ate dinner in the common area of the secure unit, and CNA #1 was asleep on the couch. 6. She sent a picture of CNA #1 sleeping on the couch to the Scheduler. 7. The Scheduler said for CNA #1 to leave the facility. 8. RN #1 woke CNA #1 up and told him to leave. 9. CNA #1 yelled and cussed at RN #1 through the unit and down the hall outside the unit. 10. She did not leave the unit but could hear CNA #1 yelling while staff escorted him through the building. G. Record review of the photo taken by CMA #1, no date, revealed the following: 1. CNA #1 sat on the couch with his head tilted to the side and his eyes closed. 2. CNA #1 had an air pod in his left ear. 3. CNA #1 had his cell phone in his hand. H. On 12/11/24 at 3:55 PM, during an interview, CNA #2 stated the following: 1. She was scheduled to work in the secure unit on 10/18/24. 2. She worked with CNA #1 during her shift on 10/18/24. 3. It was CNA #1's first shift at the facility. 4. CNA #1 frequently left the building. 5. CNA #1 had his air pods in both ears throughout the shift. 6. CNA #1 was on his phone a lot throughout the shift. 7. She had to complete all resident care herself. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	8. CNA #1 took more than an hour lunch (lunch breaks are supposed to be 30 minutes.) 9. After lunch, CNA #1 appeared intoxicated. 10. She asked CNA #1 for assistance with resident care, but he told her he was busy on a phone call. 11. She told CNA #1 multiple times that he was going to get in trouble for being on his phone and going outside frequently, and CNA #1 responded that he did not care. 12. At dinner time at 5:00 PM, all the residents were in the common area getting ready to eat dinner and CNA #1 was asleep on the couch. 13. RN #1 woke CNA #1 up. 14. CNA #1 appeared to be under the influence of something when he woke up. 15. CNA #1 became aggressive toward RN #1 and tried to hit RN #1. 16. CNA #1 out of the secure unit while RN #1 walked and yelled at RN #1. I. On 12/12/24 at 9:18 AM, during an interview, Nurse Aide (NA) #1 stated the following: 1. On 10/18/24, all the residents in the secure unit were in the common area for dinner. 2. CNA #1 was asleep on the couch. 3. CNA #1 became aggressive after RN #1 woke him up. 4. CNA #1 continued to yell at RN #1 through the secure unit and down the North hall. 5. CNA #1 tried to hit RN #1. 6. A kitchen worker stepped in to prevent CNA #1 from hitting RN #1. 7. The residents in the secure unit and North Hall were able to hear the yelling that took place between CNA #1 and RN #1. 8. She took multiple videos of the incident between CNA #1 and RN #1, because she was afraid for RN #1 and the residents. 9. She stated the police told the staff they found a bottle of alcohol in CNA #1's vehicle. J. Record review of the video footage in the secure unit, no date, revealed the following: 1. RN #1 followed CNA #1 down the North Hall. 2. RN #1 told CNA #1 to leave because he fell asleep while he was responsible for the care of 11 residents. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. CNA #1 loudly told RN #1 profanities. 4. CNA #1 turned around, approached the nurse, started yelling at the nurse, and made fists with both of his hands. 5. A male staff member approached CNA #1, and CNA #1 started yelling at the male staff member in Spanish. CNA #1 then told the staff members profanities in English. 6. RN #1 and the male staff member continued to follow CNA #1 down the hall. 7. CNA #1 got in the male staff members face and yelled to stop following him. 8. RN #1 told CNA #1 they would follow him until he was out of the building. 9. CNA #1 pulled up the sleeves of his shirt and made fists while he approached the male staff member and RN #1. 10. CNA #1 loudly said profanities at RN #1 and the male staff member. 11. CNA #3 stepped in and escorted CNA #1 out of the building. K. Record review of the police report, dated 10/19/24, revealed the following: 1. The police were called to the facility on [DATE] due to a male (CNA #1). 2. Police noticed an open alcohol container in CNA #1's vehicle and removed it. 3. On 10/19/24, police made contact with CNA #1 and he stated he was intoxicated while being at work. L. On 12/12/24 at 11:28 AM, during an interview, the DON stated the following: 1. The incident with CNA #1 and RN #1 occurred on 10/18/24, not 10/19/24 as indicated on the incident report submitted to the State Agency. 2. Staff should have notified her when CNA #1 left the building frequently, did not help with resident care, and when he fell asleep. 3. She was not notified about the events that occurred on 10/18/24 until the Scheduler notified her after the police were called. 4. She was unsure what time staff notified her on 10/28/24.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview the facility failed to report alleged allegations of abuse and neglect to the State Agency for 25 out of 25 residents on the secure unit and north hall (residents were identified by the resident census report, dated 10/18/24, provided by the Administrator on 12/13/24) sampled for abuse and neglect, when they failed to report allegations of abuse and neglect by CNA #1 on 10/18/24 within two hours after the incident. If the facility fails to report allegations of abuse and neglect timely, then corrective action may not be taken, and residents could likely suffer serious bodily injury or a decline in their psychological well-being. A. Record review of the Incident Report, dated 10/25/24, revealed the following: 1. An abuse and neglect type of incident occurred on 10/19/24 at 6:00 PM. 2. CNA #1 was asleep on the job. 3. CNA #1 smelled of alcohol. 4. CNA #1 became belligerent, was cussing at staff, and threatened to kill staff. 5. CNA #1 got into an RN's space and threatened to hit her. 6. The Incident Report was submitted to the State Agency on 10/25/24 at 4:59 PM, not within two hours of the incident. B. Record review of the Follow Up Report, dated 10/28/24, revealed the following: 1. Residents in the common area witnessed the yelling and cussing between CNA #1 and other staff. 2. The residents in the North Hall heard the yelling and cussing between CNA #1 and other staff. C. On 12/11/24 at 12:40 PM, during an interview, RN #1 stated the following: 1. She was told to communicate any concerns she may have during her shift to the Scheduler, and the scheduler would notify the DON since the DON was out of town. 2. CNA #1 was scheduled to work on 10/18/24 in the secure unit 3. On 10/18/24 (inconsistent with date on incident report) CNA #1 came in late for his first shift as a traveling CNA. 4. CNA #1 did not help CNA #2 get residents up, change the residents' briefs, or provide showers for the residents in the secure unit. 5. CNA #1 wore his air pods throughout the shift. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	6. CNA #1 frequently went to his car throughout his shift. 7. She notified the Scheduler multiple times about her concerns with CNA #1 not assisting CNA #2 with resident care, wearing his air pods, and going to his care frequently. 8. On 10/18/24 at 5:30 PM, all the residents were in the dining room, and CNA #1 was asleep on the couch. 9. On 10/18/24 at 5:30 PM, she woke CNA #1 up and told him that he needed to gather his belongings and leave the facility. 10. CNA #1 smelled like alcohol when she woke him up. 11. CNA #1 yelled profanities and threatened her. 12. CNA #1 continued to yell at her as he was escorted out of the building through the secure unit then down the North Hall. 13. She was nervous CNA #1 would hurt her or the residents. 14. CNA #1 lunged at her. 15. She felt nervous and threatened by CNA #1's behavior. 16. Police found alcohol bottles in CNA #1's car. 17. On 10/18/24, the Scheduler called the police and then notified the DON about CNA #1 yelling and cussing at staff. She was unsure of the time of the phone calls. D. On 12/11/24 at 1:58 PM, during an interview, the Scheduler stated the following: 1. 3. She worked on 10/18/24 when CNA #1 worked. 2. CNA #1 worked for an outside agency. 3. CNA #1's first time working at the facility was on 10/18/24. 4. CNA #1 was an hour late for his shift. 5. She observed CNA #1 going out to his car multiple times throughout the shift. 6. RN #1 told her CNA #1 kept going out to his car, was on his phone, and sat around. 7. She told CNA #1 he could not keep going out to his car during his shift or be on his phone. 8. On 10/18/24 at 5:30 PM, CMA #1 sent her a picture of CNA #1 sleeping on the couch in the secure unit. 9. She told staff to send CNA #1 home. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	10. CNA #1 became belligerent (hostile and aggressive) with staff when they woke him up. 11. Staff called the police due to CNA #1's behavior. 12. She went back to the facility on [DATE] when staff notified her that they called the police. 13. She notified the DON and the Administrator about the situation when she went back to the facility. She was unsure of the time of the phone calls. E. On 12/12/24 at 9:18 AM, during an interview, Nurse Aide (NA) #1 stated the following: 1. 1. On 10/18/24, all the residents in the secure unit were in the common area for dinner. 2. CNA #1 was asleep on the couch. 3. CNA #1 became aggressive after RN #1 woke him up. 4. CNA #1 continued to yell at RN #1 through the secure unit and down the North hall. 5. CNA #1 tried to hit RN #1. 6. A kitchen worker stepped in to prevent CNA #1 from hitting RN #1. 7. The residents in the secure unit and North Hall were able to hear the yelling that took place between CNA #1 and RN #1. F. On 12/12/24 at 11:28 AM, during an interview, the DON stated the following: 1. The incident with CNA #1 and RN #1 occurred on 10/18/24, not 10/19/24 as indicated on the incident report submitted to the State Agency. 2. The Scheduler notified her about the incident after the Scheduler called police. 3. She spoke with the Administrator after she was notified, and he said the Scheduler also notified him about the incident. 4. She submitted an incident report to the State Agency on 10/25/24.

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F 0943 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give their staff education on dementia care, and what abuse, neglect, and exploitation are; and how to report abuse, neglect, and exploitation. Based on record review and interview, the facility failed to provide abuse, neglect, and exploitation (ANE) training to 1 (CNA #1) of 3 (CNA #1, CNA #2, and CNA #4) staff sampled for training. This deficient practice could likely result in staff not knowing who, what, and when to report abuse, neglect, and exploitation. The findings are: A. Record review of CNA #1's training transcript, hire date 10/18/24, revealed CNA #1 did not take ANE training prior to working with residents on 10/18/24. B. On 12/11/24 at 1:58 PM, during an interview with the Scheduler, she revealed the following: 1. CNA #1 was staff member for an outside agency. 2. Agency staff do not complete facility trainings prior to working with residents at the facility. C. On 12/12/24 at 11:28 AM, during an interview with the DON, she stated the following: 1. Agency staff were required to have dementia training completed through the outside agency prior to working a shift at the facility. 2. Agency staff were not required to complete abuse, neglect, and exploitation training with the outside agency or the facility prior to working directly with residents. D. On 12/13/24 at 9:45 AM, during an interview, the Human Resources (HR) stated the following: 1. All employees are required to have abuse, neglect, and exploitation training and dementia training. 2. All employees are required to have facility onboarding to orient them to the facility. 3. CNA #1 was an agency staff member who was brought in last minute because a facility staff member called in. 4. The facility did not have an employee file for CNA #1. She stated CNA #1's first day was 10/18/24, and she (HR) was off work that day. 5. Agency staff who work for [name of agency] sometimes only work one shift, so they are unable to have them complete their trainings prior to working with residents. 6. They assumed that since [name of agency] follows State and Federal regulations, they would ensure their staff have all the trainings required for State and Federal regulations. 7. The HR did not contact the outside agency for proof that CNA #1 completed ANE training. 8. The HR did not provide any documentation to show CNA #1 completed ANE training.