

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 325044	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/06/2024
NAME OF PROVIDER OR SUPPLIER Mission Arch Center		STREET ADDRESS, CITY, STATE, ZIP CODE 3200 Mission Arch Drive Roswell, NM 88201	

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 0550</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 dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49827</p> <p>Based on interviews and record reviews, the facility failed to ensure residents were treated in a respectful manner that preserved the residents' dignity for 3 (R #1, R #3, and R #8) of 3 (R #1, R #3, and R #8) residents reviewed for residents' rights when they failed to:</p> <ol style="list-style-type: none"> 1. Allow R #1 to refuse care. 2. Assist R #3 with incontinence care as needed. 3. Allow R #8 to exercise his right to visit other residents in the facility. 4. Speak to R #8 in a dignified manner. <p>These deficient practices likely resulted in residents feeling unimportant, embarrassed, and undervalued. The findings are:</p> <p>R #1</p> <p>A. Record review of R #1's Electronic Health Record (EHR) revealed R #1 was admitted to the facility on [DATE].</p> <p>B. Record review of R #1's Admission/Entry Minimum Data Set (MDS; a federally mandated assessment instrument completed by facility staff), dated 06/26/24, indicated a Brief Interview of Mental Status (BIMS; a screening for cognitive impairment) score of 15, cognitively intact. The MDS indicated the resident was independent with activities of daily living (ADL; activities related to personal care such as bathing, showering, dressing, walking, toileting, and eating) for the areas of eating, oral hygiene, and personal hygiene. MDS also indicated R #1 required Partial/moderate assistance with toileting, showering/bathing self, and upper body dressing. MDS record indicated that R #1 required substantial/maximal assistance for lower body dressing and putting on and taking off footwear.</p> <p>(continued on next page)</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
---	-------	-----------

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 325044	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/06/2024
NAME OF PROVIDER OR SUPPLIER Mission Arch Center		STREET ADDRESS, CITY, STATE, ZIP CODE 3200 Mission Arch Drive Roswell, NM 88201	
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 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>C. On 09/10/24 at 1:44 pm, during an interview with R #1, she stated RN #1 came into her room and told her to roll over, but RN #1 did not explain why she was there. R #1 stated she explained to RN #1 that she could not roll on that side due to a humerus fracture to that arm, and RN #1 told her to roll the other way. R #1 stated RN #1 proceeded to place a fish net under her. R #1 stated she was still confused as to what was happening until RN #1 and CNA #4 wheeled in the machine (a mechanical lift). R #1 stated she told RN #1 and CNA #4, You are not putting me on that! Why do you have to put me on that? R #1 stated she did not have any idea what they were doing until the nurse attendant told her they were going to weigh her. R #1 stated she told RN #1 and CNA #4, Oh, please, please don't do this! R #1 stated she looked at RN #1 and CNA #4 and was almost screaming for them to not put her in the lift. She stated her arm was killing her, but RN #1 and CNA #4 put her in the lift anyway. R #1 stated she kept telling RN #1 that it was hurting her injured arm. R #1 stated she did not like to take her prescription pain medication and preferred to use Tylenol. She stated she was afraid of getting addicted to the prescription pain medication and opted to use only Tylenol. She stated after the staff used the mechanical lift she needed the prescription pain medication because the Tylenol was not enough. R #1 stated she saw the Orthopedic Surgeon on 06/29/24. She stated the Orthopedic Surgeon told her the plan was to continue to wear the sling and surgery was not required.</p> <p>D. Record review of R #1's Incident Report, dated 06/28/24, indicated the resident filed a grievance. The Incident Report indicated R #1 refused to go to the emergency room , and she followed-up with the Orthopedic Surgeon at a previously scheduled appointment. The Orthopedic Surgeon indicated there was not a need for surgery or change in current plan. The facility investigation that was completed by the Administrator (ADM) indicated resident allegations the Hoyer lift was against resident choice and the resident was in pain. The facility substantiated the grievance and terminated RN #1's employment.</p> <p>E. Record review of CNA #4's written statement, undated, indicated CNA #4 worked on 06/28/24. She stated RN #1 asked her to weigh R #1. CNA #4 stated she told RN #1 that R #1 was able to walk to be weighed with assistance, and she would take the resident to get weighed. CNA #4 stated RN #1 told her, Why would I take her on the scale when we can get her on the lift?</p> <p>F. On 09/04/24 at 8:40 am, during an interview with the Director of Nursing (DON), she stated her expectation was for staff to respect the resident's wishes when a resident refused treatment.</p> <p>R #3</p> <p>G. Record review of R #3's Admission Record revealed R #3 was admitted to the facility on [DATE] with the following diagnoses:</p> <ul style="list-style-type: none"> - Unspecified fracture of lower end of right tibia (the larger of the two bones in a person's lower leg). - Other fracture of upper and lower end of right fibula (the long bone that's located on the outside of the tibia bone). - Pain, unspecified. - Bipolar Disorder, unspecified. <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 325044	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/06/2024
NAME OF PROVIDER OR SUPPLIER Mission Arch Center		STREET ADDRESS, CITY, STATE, ZIP CODE 3200 Mission Arch Drive Roswell, NM 88201	
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 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<ul style="list-style-type: none"> - Muscle weakness, generalized. - Other lack of coordination. - Other reduced mobility. - Other abnormalities of gait and mobility. - Stiffness or other specified joint. <p>H. Record review of R #3's progress note, dated 08/22/24, revealed R #3 was upset with facility staff, because they told him they could not assist him with incontinence care while meal trays were in his room for fear of cross contamination.</p> <p>I. Record review of the facility's Considerate and Respectful Treatment Policy, dated 06/01/96, section Demeaning Practices, revealed staff should not refuse to assist residents with toileting during a meal.</p> <p>J. On 09/05/24 at 12:25 pm, during an interview with R #3, he stated he was supposed to wait until after he ate for the staff to help him, but he did not want to eat while he was sitting in a soiled brief. R #3 stated that it was embarrassing and uncomfortable to be left in a soiled brief. R #3 stated he could not remember the date of this incident, but it took about 30 minutes before staff assisted him with incontinence care. R #3 stated Licensed Practical Nurse (LPN) #1 told him that he could not be assisted with incontinence care while meal trays were in the room.</p> <p>K. On 09/06/24 at 8:04 am, during an interview with the Director of Nursing (DON), she confirmed LPN #1 told R #3 he could not be assisted with incontinence care until the meal trays were out of the room. The DON stated LPN #1 misunderstood the policy and has been retrained. The DON stated her expectation was for staff to assist all residents with personal care as soon as possible and especially when the resident requested it.</p> <p>R #8</p> <p>L. Record review of R #8's EHR revealed R #8 was admitted to the facility on [DATE].</p> <p>M. Record review of progress note, dated 09/03/24 at 8:43 am and written by Social Services (SS), revealed R #8 had a BIMS score of 15 and would like to move back out into the community. R #8 liked to engage in activities any time during the day and liked to participate in smoking, coffee, bingo, Karaoke, playing chess, walking outside, painting and did not spend a lot of time in individual activities.</p> <p>N. On 09/05/24 at 10:51 am, during an interview with LPN #1, she stated she observed LPN #2 yell at R #8 to go back to his room, because he did not belong in that hall. LPN #1 stated R #8 wanted to visit his friend on another unit so R # 8 yelled back at LPN #2 that he visited his friend before and it was ok. LPN #1 stated she did not tell anyone about the incident for fear of retaliation from LPN #2, because LPN #2 was good friends with the Director of Nursing (DON).</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 325044	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/06/2024
NAME OF PROVIDER OR SUPPLIER Mission Arch Center		STREET ADDRESS, CITY, STATE, ZIP CODE 3200 Mission Arch Drive Roswell, NM 88201	
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 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>O. On 09/05/24 at 3:20 pm, during an interview with R #8, he stated LPN #2 yelled at him like a damn kid to leave the unit when he tried to visit a friend on another hall. He stated he did not report the incident or file a grievance.</p> <p>P. On 09/04/24 at 8:36 am, during an interview with DON, she stated she has not seen staff yell at residents. She stated her expectation was staff should not yell at residents and would expect to be notified if it occurred.</p> <p>50207</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 325044	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/06/2024
NAME OF PROVIDER OR SUPPLIER Mission Arch Center		STREET ADDRESS, CITY, STATE, ZIP CODE 3200 Mission Arch Drive Roswell, NM 88201	
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 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50207</p> <p>Based on record review and interview, the facility failed to ensure an allegation of staff to resident abuse was reported within two hours to the State Survey Agency for 1 (R #3) of 1 (R #3) residents reviewed for reporting of alleged violations. If the facility is not immediately reporting allegations of abuse, then residents are likely to be at risk of further abuse. The findings are:</p> <p>A. Record review of R #3's Admission Record revealed R #3 was admitted to the facility on [DATE].</p> <p>B. On 09/05/24 at 12:25 pm, during an interview with R #3, he stated Certified Nurse Assistant (CNA) #1 yelled at him but he could not remember the date of the incident. R #3 stated CNA #1 came into his room to assist him with a transfer from his bed to his wheelchair. He stated CNA #1 picked up the catheter bag, but he was afraid she picked it up too far and allowed urine to re-enter his body. R #3 stated he yelled at CNA #1 to put it down. R #3 stated he could not remember exactly what CNA #1 said to him, but she yelled very loudly, and name calling was involved. R #3 stated that he reported this to the Administrator on the day that it occurred.</p> <p>C. Record review of the facility's Initial Incident Report (a report the facility submits to the State Agency describing a reportable incident), dated 08/27/24, revealed the facility received an allegation of verbal abuse by Certified Nursing Assistant (CNA) #1 towards R #3 on 08/25/24. The facility initially investigated the verbal argument as a customer service-related issue. The facility received a report from the Ombudsman on 08/27/24 regarding the same allegation. Upon notification from the Ombudsman, the facility reported the allegation to the State Survey Agency and initiated an investigation.</p> <p>D. On 09/05/24 at 10:50 am and 2:46 pm, during an interview with the Administrator (ADM), he stated he is responsible for submitting allegations of abuse to the State Survey Agency. The ADM confirmed that this allegation was reported to the State Survey Agency on 08/27/24. He stated his expectation is for all allegations of abuse to be reported to the State Survey Agency as required.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 325044	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/06/2024
NAME OF PROVIDER OR SUPPLIER Mission Arch Center		STREET ADDRESS, CITY, STATE, ZIP CODE 3200 Mission Arch Drive Roswell, NM 88201	

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 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50207</p> <p>Based on record review and interview, the facility failed to complete and document a thorough investigation for 1 (R #3) of 1 (R #3) residents when staff failed to:</p> <ol style="list-style-type: none"> 1. Complete a thorough investigation regarding an allegation of abuse. 2. Provide a follow-up report to the State Agency within five working days from the date of the incident. <p>If the facility fails to complete a thorough investigation and five day follow-up report then residents are likely to feel frustrated and unsafe. The findings are:</p> <p>A. Record review of R #3's Admission Record revealed R #3 was admitted to the facility on [DATE].</p> <p>B. Record review of R #3's hospital discharge documentation, dated 08/17/24, revealed the resident had an indwelling urinary catheter (a medical device that drains urine from the bladder) placed at the hospital.</p> <p>C. On 09/05/24 at 12:25 pm, during an interview with R #3, he stated Certified Nurse Assistant (CNA) #1 yelled at him but he could not remember the date of the incident. R #3 stated CNA #1 came into his room to assist him with a transfer from his bed to his wheelchair. He stated CNA #1 picked up the catheter bag, but he was afraid she picked it up too far and allowed urine to re-enter his body. R #3 stated he yelled at CNA #1 to put it down. R #3 stated he could not remember exactly what CNA #1 said to him, but she yelled very loudly, and name calling was involved. R #3 stated that he reported this to the Administrator on the day that it occurred.</p> <p>D. Record review of the facility's Initial Incident Report (a report the facility submits to the State Agency describing a reportable incident), dated 08/27/24, revealed an allegation of verbal abuse by Certified Nursing Assistant (CNA) #1 towards R #3 on 08/25/24. This report was filed by the Administrator.</p> <p>E. Record review of the facility's Complaint Narrative Investigation Report (a follow-up report due to the State Survey Agency within five working days) revealed the following:</p> <ol style="list-style-type: none"> 1. CNA #1 confirmed the verbal argument. 2. The incident was labeled as unsubstantiated (not supported or proven by evidence). 3. The facility did not document observations or interviews with other residents to determine if other incidents occurred. 4. The report was submitted to the State Survey Agency on 09/05/24 at 11:18 pm. <p>(continued on next page)</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 325044	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/06/2024
NAME OF PROVIDER OR SUPPLIER Mission Arch Center		STREET ADDRESS, CITY, STATE, ZIP CODE 3200 Mission Arch Drive Roswell, NM 88201	
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 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>F. On 09/05/24 at 10:50 am and 2:46 pm, during an interview with the Administrator (ADM), he stated he is responsible for completing and submitting the Complaint Narrative Investigation Reports to the State Survey Agency. The ADM confirmed he partially substantiated the complaint due to CNA #1 admitting the verbal argument occurred. He stated he received an extension for the follow-up report, making the new due date 09/02/24. He confirmed other residents were not interviewed during this investigation. The ADM stated his expectation is for thorough investigations to be completed and documented according to the required timeframes.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 325044	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/06/2024
NAME OF PROVIDER OR SUPPLIER Mission Arch Center		STREET ADDRESS, CITY, STATE, ZIP CODE 3200 Mission Arch Drive Roswell, NM 88201	

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 0655</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</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** 49827</p> <p>Based on observations, record reviews, and interviews, the facility failed to ensure baseline care plans were completed for 1 (R #2) out of 1 (R #2) residents reviewed for care plans. This deficient practice could likely result in staff not understanding and implementing the needs and treatments of residents. The findings are:</p> <p>A. On 09/04/24 at 12:56 pm during an interview with R #2, he stated he required some help with transferring, because he could not stand well on the foot he had surgery on. He stated staff also help him with showering to prevent his wound from getting wet.</p> <p>B. Record review of R #2's Electronic Health Record (EHR) revealed the following:</p> <ol style="list-style-type: none"> 1. R #2 was admitted on [DATE] for surgical aftercare after removal of the small fifth toe to the left foot, diabetes, high cholesterol and an infection in the surgical site. 2. The record did not contain a baseline care plan. <p>C. On 09/06/24 at 8:17 am, during an interview with the Director of Nursing (DON), she stated she was unable to find a care plan in R #2's EHR. She stated her expectation was for staff to completed the resident's baseline care plan or a comprehensive careplan on admission within 48 hours.</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 325044	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/06/2024
NAME OF PROVIDER OR SUPPLIER Mission Arch Center		STREET ADDRESS, CITY, STATE, ZIP CODE 3200 Mission Arch Drive Roswell, NM 88201	
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 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</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** 49827</p> <p>Based on observations, record reviews, and interviews, the facility failed to ensure care plans were accurate and complete for 2 (R #3 and R #4) out of 2 (R #3 and R #4) residents reviewed for comprehensive care plans. This deficient practice could likely result in staff not understanding and implementing the needs and treatments of residents. The findings are:</p> <p>R #3</p> <p>A. Record review of R #3's EHR revealed R #3 was admitted on [DATE].</p> <p>B. Record review of R #3's hospital discharge documentation, dated 08/17/24, revealed the resident had an indwelling urinary catheter (a medical device that drains urine from the bladder) placed when he went to the hospital.</p> <p>C. On 09/05/24 at 12:25 pm, during an interview and observation of R #3, the resident stated he had an indwelling urinary catheter placed when he went to the hospital in August. Observation revealed the resident's catheter bag hung on the side of his bed.</p> <p>D. Record review of R #3's care plan, last updated on 08/10/24, revealed the following:</p> <ol style="list-style-type: none"> Staff did not document R #3 had an indwelling urinary catheter on the care plan. Staff did not document instructions for how to care for R #3's indwelling urinary catheter in the care plan. <p>E. On 09/06/24 at 8:04 am, during an interview with the Director of Nursing (DON), she confirmed the following:</p> <ol style="list-style-type: none"> R #3 had an indwelling urinary catheter placed during a visit to the hospital on 08/17/24. R #3's care plan did not indicate R #3 had an indwelling urinary catheter. R #3's care plan did not indicate how staff should care for R #3's indwelling urinary catheter. Resident care plans should indicate if the resident had an indwelling urinary catheter and instructions for care. <p>R #4</p> <p>F. Record review of R #4's EHR revealed R #4 was admitted on [DATE].</p> <p>G. On 09/05/24 at 12:19 pm, during an observation, R #4 had a catheter bag which hung from the side of his bed.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 325044	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/06/2024
NAME OF PROVIDER OR SUPPLIER Mission Arch Center		STREET ADDRESS, CITY, STATE, ZIP CODE 3200 Mission Arch Drive Roswell, NM 88201	
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 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>H. Record review of R #4's care plan, last updated on 08/06/24, revealed the following:</p> <ol style="list-style-type: none"> 1. Staff did not document R #4 had a Foley catheter (a medical device that drains urine from the bladder) on the care plan. 2. Staff did not document instructions on how to care for R #4's Foley catheter in the care plan. <p>I. During an interview with the DON, she confirmed the following:</p> <ol style="list-style-type: none"> 1. R #4 had a Foley catheter. 2. R #4's care plan did not indicate R #4 had a Foley catheter. 3. R #4's care plan did not indicate how staff should care for R #4's Foley catheter. 4. Resident care plans should indicate if the resident had a Foley catheter and instructions for care. <p>50207</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 325044	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/06/2024
NAME OF PROVIDER OR SUPPLIER Mission Arch Center		STREET ADDRESS, CITY, STATE, ZIP CODE 3200 Mission Arch Drive Roswell, NM 88201	
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 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure services provided by the nursing facility meet professional standards of quality.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38450</p> <p>Based on observations, record reviews, and interviews, the facility failed to meet professional standards of quality for 3 (R #3, R #4, R #6) of 5 (R #3, R #4, R #5, R #6, and R #9) residents when staff:</p> <ol style="list-style-type: none"> Failed to properly transfer R #3 causing his indwelling urinary catheter (a medical device that drains urine from the bladder) to be pulled out. Failed to obtain physician orders for the use and care of resident's catheters. Failed to handle and assist a resident with medications in a safe manner. <p>If the facility is not providing care that meets professional standards of quality, then residents are likely to experience pain, discomfort and not get the care they need.</p> <p>The findings are:</p> <p>Transfers</p> <p>A. Record review of R #3's Admission Record revealed R #3 was admitted to the facility on [DATE] with the following diagnoses:</p> <ul style="list-style-type: none"> -Unspecified fracture of lower end of right tibia (the larger of the two bones in a person's lower leg). -Other fracture of upper and lower end of right fibula (the long bone that's located on the outside of the tibia bone). -Pain, unspecified. -Other muscle spasm. -Muscle weakness, generalized. -Other lack of coordination. -Other reduced mobility. -Other abnormalities of gait and mobility. -Stiffness or other specified joint. <p>B. Record review of R #3's hospital discharge documentation, dated 08/17/24, revealed the resident had an indwelling urinary catheter placed when he went to the hospital.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 325044	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/06/2024
NAME OF PROVIDER OR SUPPLIER Mission Arch Center		STREET ADDRESS, CITY, STATE, ZIP CODE 3200 Mission Arch Drive Roswell, NM 88201	
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 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>C. On 09/05/24 at 12:25 pm, during an observation and interview, R #3 had an indwelling urinary catheter which hung on the side of his bed. R #3 stated his indwelling urinary catheter was pulled out when staff transferred him from his bed to his wheelchair. R #3 stated the staff member forgot to unhook the catheter bag from the rail on his bed, and it was pulled out as staff transferred him to his wheelchair. The resident could not remember the date this occurred.</p> <p>D. Record review of R #3's Electronic Health Record (EHR) revealed the record did not contain an incident note, a nurse assessment, or further explanation of the incident where R #3's indwelling urinary catheter was pulled out during a transfer.</p> <p>E. On 09/06/24 at 8:04 am, during an interview with the Director of Nursing (DON), she confirmed a facility nurse replaced R #3's indwelling urinary catheter after a Certified Nursing Assistant (CNA) accidentally pulled it out during transfer. The DON was not able to find any information regarding this incident in R #3's EHR and could not remember which CNA was responsible. The DON stated she expected CNAs to unhook the bag and move it with the resident during transfers.</p> <p>Physician Orders</p> <p>F. Record review of R #3's hospital discharge documentation, dated 08/17/24, revealed the resident had an indwelling urinary catheter placed when he went to the hospital. This document contained generic information regarding a catheter but did not contain orders on size of the tubing or bulb and did not contain orders for the care or maintenance of the catheter.</p> <p>G. On 09/05/24 at 12:25 pm, during an interview and observation of R #3, the resident stated he had an indwelling urinary catheter placed when he went to the hospital in August. Observation revealed the resident's catheter bag hung on the side of his bed.</p> <p>H. Record review of R #3's current physician orders revealed the record did not contain an orders for R 3's indwelling urinary catheter or catheter care.</p> <p>I. Record review of R #3's care plan, last updated on 08/10/24, revealed the following:</p> <ol style="list-style-type: none"> 1. Staff did not document R #3 had an indwelling urinary catheter on the care plan. 2. Staff did not document instructions for how to care for R #3's indwelling urinary catheter in the care plan. <p>J. On 09/06/24 at 8:04 am, during an interview with the Director of Nursing (DON), she stated the following:</p> <ol style="list-style-type: none"> 1. R #3 had an indwelling urinary catheter placed during a visit to the hospital on 08/17/24. 2. The resident's record did not contain orders for R 3's indwelling urinary catheter or catheter care. 3. There should be current orders in place for residents that have an indwelling urinary catheter. <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 325044	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/06/2024
NAME OF PROVIDER OR SUPPLIER Mission Arch Center		STREET ADDRESS, CITY, STATE, ZIP CODE 3200 Mission Arch Drive Roswell, NM 88201	
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 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>4. Her expectation is for the nurse on duty to review discharge documentation from the hospital and to contact the medical provider for any needed orders.</p> <p>R #4</p> <p>K. Record review of R #4's Admission Record revealed R #4 was readmitted on [DATE] with multiple diagnoses including:</p> <ul style="list-style-type: none"> -Cellulitis (deep inflammation of the tissues just under the skin; caused by infection). -Difficulty in walking. -Paroxysmal Atrial Fibrillation (an irregular, often rapid heart rate that commonly causes poor blood flow). -Muscle weakness, generalized. -Other lack of coordination. -Dehydration -Urinary Tract Infection (UTI; an infection in any part of the urinary system, which includes the kidneys, ureters, bladder, and urethra). <p>L. Record review of R #4's Baseline Care Plan dated 08/12/24, revealed he was readmitted with a catheter.</p> <p>M. On 09/05/24 at 12:19 pm, during an observation, R #4 had a catheter bag hanging from the side of his bed.</p> <p>N. Record review of R #4's current physician orders revealed the record did not contain orders for R #4's Foley catheter or catheter care.</p> <p>O. Record review of R #4's care plan, last updated on 08/06/24, revealed the following:</p> <ol style="list-style-type: none"> 1. Staff did not document R #4 had a Foley catheter on the care plan. 2. Staff did not document instructions on how to care for R #4's Foley catheter in the care plan. <p>P. On 09/06/24 at 8:04 am, during an interview with the Director of Nursing (DON), she stated the following:</p> <ol style="list-style-type: none"> 1. R #4 had a Foley catheter. 2. The resident's the record did not contain orders for R 4's Foley catheter or catheter care. 3. There should be current orders in place for residents that have Foley catheters. <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 325044	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/06/2024
NAME OF PROVIDER OR SUPPLIER Mission Arch Center		STREET ADDRESS, CITY, STATE, ZIP CODE 3200 Mission Arch Drive Roswell, NM 88201	

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 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>4. Her expectation is for the nurse on duty during admission to contact the medical provider for any needed orders.</p> <p>Safe Handling of Medications</p> <p>R #6</p> <p>Q. On 09/04/24 at 08:40 am, during a random observation, Certified Medical Assistant (CMA) #2 was preparing medications for R #6 when she opened a Depakote Sprinkles medication capsule and was not wearing gloves. She used her hand to sweep the medication powder off the cart and onto the floor. CMA #2 exposed herself to the medication by touching the medication powder and resident failed to receive the entire content of the capsule.</p> <p>R. On 09/06/24 at 8:17 am, during an interview with the DON, she stated staff should wear gloves when handling medications.</p> <p>S. Review of the Food and Drug Administration (FDA) website https://www.fda.gov/drugsatfda stated that Depakote Sprinkles capsules must be handled carefully and if the contents of the capsule are spilled you should start over with new capsule.</p> <p>50207</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 325044	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/06/2024
NAME OF PROVIDER OR SUPPLIER Mission Arch Center		STREET ADDRESS, CITY, STATE, ZIP CODE 3200 Mission Arch Drive Roswell, NM 88201	
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 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p>49827</p> <p>Based on observation and interviews, the facility failed to ensure all treatment carts were locked while unattended.</p> <p>This deficient practice had the potential to affect all 103 people residing in the facility by allowing unauthorized persons access to their medical supplies and personal health information.</p> <p>The findings are:</p> <p>A. On 09/04/24 at 8:19 am, during a random observation of the facility, the treatment cart located in front of the memory unit by nurses stations was unlocked and unattended.</p> <p>B. On 09/04/24 at 8:20 am, during an interview with Certified Nursing Assistant (CNA) #5, she confirmed the treatment cart was unlocked but should be locked.</p> <p>C. On 09/04/24 at 8:20 am, during an interview with Licensed Practical Nurse (LPN) #1, she confirmed the treatment cart should be locked when unattended.</p> <p>D. On 09/04/24 at 1:16 pm, during a random observation of the facility, the treatment cart in front of the memory unit by the nurses station was unlocked and unattended.</p> <p>E. On 09/04/24 at 1:20 pm, during an interview with LPN #1, she confirmed the treatment cart should be locked when unattended.</p> <p>F. On 09/05/24 at 11:50 am, during a random observation of 100 hall, medication cart was unlocked and unattended.</p> <p>G. On 09/05/24 at 11:55 am, during an interview with Certified Medical Assistant (CMA) #3, she confirmed that the medication cart should be locked.</p> <p>H. On 09/06/24 at 8:10 am, during an interview with the Director of Nursing (DON), she stated the treatment cart should be locked and secured while not in use.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 325044	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/06/2024
NAME OF PROVIDER OR SUPPLIER Mission Arch Center		STREET ADDRESS, CITY, STATE, ZIP CODE 3200 Mission Arch Drive Roswell, NM 88201	
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 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50207</p> <p>Based on record review and interview, the facility failed to ensure medical records were complete and accurate for 1 (R #3) of 1 (R #3) residents reviewed. This deficient practice could likely result in staff not being aware of the residents' daily care events, changes, and needs. The findings are:</p> <p>A. Record review of R #3's Admission Record revealed R #3 was admitted to the facility on [DATE] with the following diagnoses:</p> <ul style="list-style-type: none"> -Unspecified fracture of lower end of right tibia (the larger of the two bones in a person's lower leg). -Other fracture of upper and lower end of right fibula (the long bone that's located on the outside of the tibia bone). -Pain, unspecified. -Other muscle spasm. -Muscle weakness, generalized. -Other lack of coordination. -Other reduced mobility. -Other abnormalities of gait and mobility. -Stiffness or other specified joint. <p>B. Record review of R #3's hospital discharge documentation, dated 08/17/24, revealed the resident had an indwelling urinary catheter placed.</p> <p>C. On 09/05/24 at 12:25 pm, during an observation and interview, R #3 had an indwelling urinary catheter which hung on the side of his bed. R #3 stated his indwelling urinary catheter was pulled out when the staff transferred him from his bed to his wheelchair. R #3 stated the staff member forgot to unhook the catheter bag from the rail on his bed, and it was pulled out as staff transferred him to his wheelchair. The resident could not remember the date this occurred.</p> <p>D. Record review of R #3's Electronic Health Record (EHR) revealed the record did not contain an incident note, a nurse assessment, or further explanation of the incident where R #3's indwelling urinary catheter was pulled out during a transfer.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 325044	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/06/2024
NAME OF PROVIDER OR SUPPLIER Mission Arch Center		STREET ADDRESS, CITY, STATE, ZIP CODE 3200 Mission Arch Drive Roswell, NM 88201	

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 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>E. On 09/06/24 at 8:04 am, during an interview with the Director of Nursing (DON), she confirmed a facility nurse replaced R #3's indwelling urinary catheter after a Certified Nursing Assistant (CNA) accidentally pulled it out during transfer. The DON was not able to find any information regarding this incident in R #3's EHR. The DON stated she expected all records to be accurate and complete.</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 325044	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/06/2024
NAME OF PROVIDER OR SUPPLIER Mission Arch Center		STREET ADDRESS, CITY, STATE, ZIP CODE 3200 Mission Arch Drive Roswell, NM 88201	
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 0947</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention.</p> <p>50207</p> <p>Based on record review and interview, the facility failed to ensure Certified Nurse Aides (CNAs) received the required in-service training of 12 hours per year for 3 (CNA #1, CNA #2, and CNA #3) out of 3 (CNA #1, CNA #2, and CNA #3) CNAs reviewed for required in-service training. This deficient practice is likely to result in the CNAs not receiving the necessary training to meet the care needs of the residents. The findings are:</p> <p>CNA #1</p> <p>A. Record review of CNA #1's personnel file revealed CNA #1 was hired on 05/19/23.</p> <p>B. Record review of CNA #1's in-service training Transcript Report, dated 09/05/24, revealed CNA #1 did not complete any trainings from 05/19/23 to 09/05/24.</p> <p>C. On 09/05/24 at 4:23 pm, during an interview with the Administrator (ADM), he confirmed CNA #1 did not complete any trainings while she was employed at the facility. He confirmed that CNA #1 continued to work shifts providing care for residents in the facility even though she had completed no trainings. The ADM stated he expected all CNAs to complete at least 12 hours of training per year.</p> <p>CNA #2</p> <p>D. Record review of CNA #2's personnel file revealed CNA #2 was hired on 04/27/23.</p> <p>E. Record review of CNA #2's in-service training Transcript Report, dated 09/05/24, revealed CNA #2 completed two out of 12 hours of the required annual training from 04/27/23 to 09/05/24.</p> <p>F. On 09/05/24 at 4:23 pm, during an interview with the Administrator (ADM), he confirmed CNA #2 completed two out of 12 hours of the required annual training. He confirmed that CNA #2 continued to work shifts providing care for residents in the facility even though she had not completed the required trainings. The ADM stated he expected all CNAs to complete at least 12 hours of training per year.</p> <p>CNA #3</p> <p>G. Record review of CNA #3's personnel file revealed CNA #3 was hired on 09/12/22.</p> <p>H. Record review of CNA #3's in-service training Transcript Report, dated 09/05/24, revealed CNA #3 completed four out of 12 hours of the required annual training from 09/05/23 to 09/05/24.</p> <p>I. On 09/05/24 at 4:23 pm, during an interview with the Administrator (ADM), he confirmed CNA #3 had only completed four out of 12 hours of the required annual training. He confirmed that CNA #3 continued to work shifts providing care for residents in the facility even though she had not completed the required trainings. The ADM stated he expected all CNAs to complete at least 12 hours of training per year.</p>		