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 02/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mission Arch Center	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)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49827 Based on record review and interview, the facility failed to notify the physician of a change in condition in which a resident developed a fever for 1 (R #1) of 1 (R #1) residents reviewed. This deficient practice likely resulted in the resident receiving medication against physician orders. The findings are: A. Record review of R #1's admission record revealed the following: 1. admitted [DATE]. 2. Diagnoses included the following: a. Unspecified Dementia (a group of conditions characterized by impairment of at least two brain functions, such as memory loss and judgment), unspecified severity, without behavioral disturbance, psychotic (a mental health condition characterized by a loss of contact with reality) disturbance, psychotic disturbance, mood disturbance, and anxiety, b. Unspecified dementia, severe, without behavioral disturbance, c. Cognitive (conscious intellectual activity) communication deficit, d. Muscle weakness (generalized), e. Old Myocardial (relating to the muscle tissue of the heart) Infarction (obstruction of the blood supply to an organ or geion of tissue), f. Need for Assistance with Personal Care, g. Encephalopathy (medical condition characterized by a general impairment of brain function), unspecified, h. Urinary (tract infection, site not specified) i. Depression (mental condition characterized by a persistent low mood, loss of interest or pleasure in activities, and changes in behavior and thinking), Unspecified, (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	325044	A. Building B. Wing	02/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	j. Insomnia (difficulty falling asleep), Unspecified. B. Record review of R #1's physician orders dated 07/29/24, revealed an order for Acetaminophen Oral Tablet give 650 milligrams (mg) by mouth every four hours as needed for pain/fever. C. Record review of R #1's Physicians History and Physical recommendations section dated 07/31/2024, revealed the As needed (PRN) Tylenol order, changing Tylenol to be given for pain only; if fever occurs the physician should be notified before giving Tylenol [acetaminophen]. D. Record review of R #1's progress notes revealed staff documented the following: 1. On 08/17/24 at 1:03 pm, nursing staff documented a late entry of administration of Tylenol 650 mg and was administered for low grade fever of 100.3 F. 2. On 08/17/24 at 1:53 pm, nursing staff documented Tylenol was effective without documenting the new temperature. 3. On 08/17/24 at 7:48 pm, nursing staff documented the administration of Tylenol 650 mg, however documentation does not indicate the reason Tylenol was given. 4. On 08/18/24 at 5:03 am, nursing staff documented Tylenol was effective. E. On 02/07/25 at 1:52 pm, during an interview with the DON confirmed documentation in R #1's electronic health record (EHR) did not indicate that the Physician was not notified of R #1's fever. F. On 02/25/25 at 2:15 pm, during an interview with the medical director (MD), she confirmed that staff should follow any order that a provider writes so a provider should have been contacted when R #1 developed a fever. 50207

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NAME OF PROVIDER OR SUPPLIER Mission Arch Center		STREET ADDRESS, CITY, STATE, ZIP CODE 3200 Mission Arch Drive Roswell, NM 88201	

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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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49827 Based on record review and interview, the facility failed to ensure quality care that meets professional standards for 1 (R #1) of 1 (R #1) residents reviewed when the facility failed to follow a medical order and notify the provider about changes in a resident's onset of a fever. Failure to implement care orders and notify the provider about changes in resident's vital signs could likely lead to facility staff and the physician being unaware of changes in resident condition and could likely lead to worsening of resident's condition. The findings are: A. Record review of R #1's admission record revealed the following: 1. admitted [DATE]. 2. Diagnoses included the following: a. Unspecified Dementia (a group of conditions characterized by impairment of at least two brain functions, such as memory loss and judgment), unspecified severity, without behavioral disturbance, psychotic (a mental health condition characterized by a loss of contact with reality) disturbance, psychotic disturbance, mood disturbance, and anxiety, b. Unspecified dementia, severe, without behavioral disturbance, c. Cognitive (conscious intellectual activity) communication deficit, d. Muscle weakness (generalized), e. Old Myocardial (relating to the muscle tissue of the heart) Infarction (obstruction of the blood supply to an organ or geion of tissue), f. Need for Assistance with Personal Care, g. Encephalopathy (medical condition characterized by a general impairment of brain function), unspecified, h. Urinary (tract infection, site not specified) i. Depression (mental condition characterized by a persistent low mood, loss of interest or pleasure in activities, and changes in behavior and thinking), Unspecified, j. Insomnia (difficulty falling asleep), Unspecified. B. Record review of physician orders dated 07/29/24, revealed the following: 1. Acetaminophen Oral Tablet give 650 milligrams (mg) by mouth every four hours as needed for pain/fever. (continued on next page)

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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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	C. Record review of R #1's Physicians History and Physical dated 07/31/2024, revealed the following: 1. admitted to the facility for diagnosis of dementia and a progressive decline in cognitive status is unavoidable. 2. Recommendations section amended the As needed (PRN) Tylenol order, changing Tylenol to be given for pain only; if fever occurs the physician should be notified before giving Tylenol [acetaminophen]. D. Record review of R #1's progress notes revealed staff documented the following: 1. On 08/17/24 at 1:03 pm, nursing staff documented a late entry of administration of Tylenol 650 mg and was administered for low grade fever of 100.3 F. 2. On 08/17/24 at 1:53 pm, nursing staff documented Tylenol was effective without documenting the new temperature. 3. On 08/17/24 at 7:48 pm, nursing staff documented the administration of Tylenol 650 mg, however documentation does not indicate the reason Tylenol was given. 4. On 08/18/24 at 5:03 am, nursing staff documented Tylenol was effective. E. On 02/25/25 at 2:15 pm, during an interview with the medical director (MD), she confirmed that staff should follow any order that is written by any physician and the provider should have been contacted with R #1 developed a fever or any change in condition before the Tylenol was administered.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49827 Based on record review and interview, the facility failed to ensure medical records were complete and accurate for 2 (R #1 and R #5) of 6 (R #1, R #2, R #3, R #4, R #5, and R #6) 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: R #1 A. Record review of R #1's Admission Record revealed R #1 was admitted to the facility on [DATE] with the following diagnoses: 1. Unspecified Dementia (a group of conditions characterized by impairment of at least two brain functions, such as memory loss and judgment), unspecified severity, without behavioral disturbance, psychotic (a mental health condition characterized by a loss of contact with reality) disturbance, psychotic disturbance, mood disturbance, and anxiety, 2. Unspecified dementia, severe, without behavioral disturbance, 3. Cognitive (conscious intellectual activity) communication deficit, 4. Muscle weakness (generalized), 5. Old Myocardial (relating to the muscle tissue of the heart) Infarction (obstruction of the blood supply to an organ or geion of tissue), 6. Need for Assistance with Personal Care, 7. Encephalopathy (medical condition characterized by a general impairment of brain function), unspecified, 8. Urinary (tract infection, site not specified 9. Depression (mental condition characterized by a persistent low mood, loss of interest or pleasure in activities, and changes in behavior and thinking), Unspecified, 10. Insomnia (difficulty falling asleep), Unspecified. B. Record review of R #1's hospital documentation, dated [DATE], revealed R #1 arrived at the hospital on [DATE] complaining of difficulty breathing. C. Record review of R #1's Electronic Health Record (EHR) revealed the record did not contain a change of condition, assessment of symptoms, or progress notes indicating the need to transfer R #1 for shortness of breath, or further explanation of the reason R #1 required a higher level of care. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	D. Record review of R #1's progress notes revealed staff documented the following: 1. On [DATE] at 1:03 pm, nursing staff documented a late entry of administration of Tylenol 650 mg and was administered for low grade fever of 100.3 F. 2. On [DATE] at 1:53 pm, nursing staff documented Tylenol was effective without documenting the new temperature. 3. On [DATE] at 7:48 pm, nursing staff documented the administration of Tylenol 650 mg, however documentation does not indicate the reason Tylenol was given. 4. On [DATE] at 5:03 am, nursing staff documented Tylenol was effective. E. Record review of R #1's vital signs dated [DATE] at 4:59 pm revealed R #1's blood pressure was , d+[DATE] mmHg, (normal range, ,d+[DATE] mm/Hg (millimeters of mercury; how blood pressure is measured) to ,d+[DATE] mmHg), pulse was 68 beats per minute (bpm (normal range ,d+[DATE] beats per minute), respirations was 16 breaths per minute (normal range, 12 to 20 breaths per minute; recorded breaths per minute), oxygen saturation level was 92% on room air (amount of oxygen circulating in a person's blood), and temperature was 98.4 degrees. This was the last documented set of vitals by facility staff. F. Record review of R #1's hospital records dated [DATE], revealed the following 1. R #1 presented to the emergency room by ambulance complaining of difficulty breathing and shortness of breath, but according to hospital records R #1 was able to answer questions, and stated she was short of breath. 2. R #1 appeared to be in no apparent distress, behavior was appropriate for age, and she was interacting with others upon admission. G. On [DATE] at 1:12 pm, during an interview, Certified Nurses Aide (CNA) #1 stated she remembered R #1 she was a real healthy lady. She stated on Sunday [DATE], R #1 got up early to get ready for breakfast. After she got up, R #1 told CNA #1, she did not feel well, she vomited and went back to bed. CNA #1 stated she notified the nurse that R #1 was not feeling well and vomited. CNA #1 stated she recalled that R #1 had to be sent to the hospital on [DATE] early in the morning around shift change. H. On [DATE] at 1:52 pm, during an interview with the DON, the following was confirmed: 1. Vital signs were not recorded after [DATE] that indicated elevated temperatures or problems with breathing or oxygen saturation. 2. R #1's EHR did not contain any documentation or notes indicating the change of condition or incident that led to the ambulance being called and R #1 being sent to the emergency room . 3. She expected all records to be accurate and complete. R #5 (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	I. Record review of R #5's Admission Record revealed R #5 was admitted to the facility on [DATE] with the following diagnoses: 1. Dysphagia, Oropharyngeal Phase 2. Gastro-Esophageal Refulx Disease Without Esophagitis 3. Benign Prostatic Hyperplasia Without Lower Urinary Tract Symptoms 4. Other Lack of Coordination 5. Muscle Weakness 6. Personal History of Transient Ischemic Attack (TIA), and Cerbral Infacrction Without Residual Deficits J. Record review of R #5's EHR revealed R #5 was referred to Hospice services on [DATE]. K. Record review of R #5's EHR revealed staff did not provide the required documentation or describe the events leading up to the change in R #5's condition prior to his death on [DATE]. L. On [DATE] at 1:52 pm, during an interview with the Director of Nursing (DON), she confirmed R #5's EHR did not contain any documentation describing the events leading up to the death of R #5's, she confirmed a change in condition should be completed any time a resident has a change from the baseline. The DON stated she expected all records to be accurate and complete.