

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

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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 325116	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/10/2026
NAME OF PROVIDER OR SUPPLIER Mescalero Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 454 Lipan Avenue Mescalero, NM 88340	
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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to provide the required transfer information for 3 (R #8, R #9, and R #10) of 3 (R #8, R #9, and R #10) residents reviewed for transfers when staff failed to: 1. Notify R #8, R #9, and R #10 and their representative(s) of the residents' transfer to the hospital in writing and in a language and manner they understand. 2. Ensure R #8, R #9, R #10 and their representative(s) receive a written notice of bed hold which indicated the duration the resident's bed would be held. These deficient practices could likely result in the residents and/or their representatives not knowing the reason for the transfer, the location of the transfer, their rights to advocate and make informed decisions. The findings are: R #8A. Record review of R #8's admission Record, no date, revealed R #8 was admitted to the facility on [DATE]. B. Record review of R #8's nursing progress notes, revealed the following: 1. On 03/21/26 R #8 was sent to the hospital due to altered mental status. 2. On 05/29/26 R #8 was sent to the hospital due to nausea and vomiting. C. Record review of R #8's Bed Hold Notification, dated 03/21/26, revealed staff did not document the number of days the bed will be held, or the amount the bed hold would cost R #8 after the number of days held. D. Record review of R #8's medical record revealed staff did not complete the following: 1. A Bed Hold Notification for R #8's transfer to the hospital on [DATE]. 2. A transfer notice to the hospital on [DATE] or 05/29/26. R #9E. Record review of R #9's admission Record, no date, revealed R #9 was admitted to the facility on [DATE]. F. Record review of R #9's nursing progress notes, revealed on 04/11/26 R #9 was sent to the hospital due to altered mental status. G. Record review of R #9's Bed Hold Notification, dated 04/11/26, revealed staff did not document the number of days the bed will be held, or the amount the bed hold would cost R #9 after the number of days held. H. Record review of R #9's medical record, no date, revealed staff did not complete a transfer notice to the hospital on [DATE]. R #10I. Record review of R #10's admission Record, no date, revealed R #10 was admitted to the facility on [DATE]. J. Record review of R #10's nursing progress notes, revealed R #10 was sent to the hospital due to dehydration on 05/30/26 K. Record review of R #10's medical record, no date, revealed staff did not complete the following: 1. A Bed Hold Notification for R #10's transfer to the hospital on [DATE]. 2. A Transfer Notification for R #10's transfer to the hospital on [DATE]. L. On 06/10/26 at 9:21 AM, during an interview, the ADON confirmed that staff were not completing written transfer notices when residents are transferred from the facility. M. On 06/10/26 at 9:22 AM, during an interview, the DON confirmed that staff are not documenting the number of days a bed will be held or the amount the bed hold would cost the residents.		

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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