STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	325057	A. Building B. Wing	05/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lovington Health Care	1600 West Ave I Lovington, NM 88260

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41988 Based on observation, record review, and interview, the facility failed to meet professional standards of quality for 1 (R #1) of 1 (R #1) residents when staff failed to: 1. Reposition R #1 in accordance with her care plan. 2. Communicate among staff and document when R #1 was repositioned. If the facility is not repositioning a resident per their care plan then residents are likely to not receive the therapeutic benefits and care needed. The findings are: A. Record review of R #1's face sheet revealed R #1 was admitted into the facility on [DATE] with the following diagnoses: 1. Stroke. 2. Muscle weakness. 3. Dysphagia (condition with difficulty in swallowing food or liquid). B. Record review of R #1's care plan, dated 05/15/24, revealed the following: - Focus: The resident had potential/actual impairment to skin integrity related to fragile skin. - Interventions: Educate resident/family/caregivers of causative factors and measure to prevent skin injury. Turn resident using the clock for repositioning. C. On 05/15/24 at 12:19 pm during an observation of R #1's room, a repositioning clock was located on the wall across from R #1's bed. The repositioning clock indicated the following: - At 12:00 am and pm, staff to reposition R #1 on her back. - At 2:00 am and pm, staff to reposition R #1 on her left side. - At 4:00 am and pm, staff to reposition R #1 on her right side. (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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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- At 6:00 am and pm, staff to reposition R #1 on her back. - At 8:00 am and pm, staff to reposition R #1 on her left side. - At 10:00 am and pm, staff to reposition R #1 on her right side. D. On 05/15/24 at 2:43 pm during an observation, R #1 lay on her back and was not positioned on her left side as indicated by the repositioning clock. E. On 05/16/24 at 10:19 am during an observation, R #1 lay on her back and was not positioned on her right side as indicated by the repositioning clock. F. On 05/16/24 at 10:21 am during an interview with Licensed Practical Nurse (LPN) #1, she stated staff were supposed to reposition R #1 every two hours, but she did not know how to read the repositioning clock that was on R #1's wall. LPN #1 stated the CNAs (Certified Nursing Assistants) were responsible to reposition R #1 and document it. G. On 05/16/24 at 11:21 am during an interview with CNA #1, he stated R #1 should be repositioned every two hours according to the repositioning clock on the resident's wall. CNA #1 also stated, Right now, she [R #1] should be on her right side, but she's still on her back. We should have repositioned her already. H. On 05/16/24 at 12:24 pm during an interview with the Assistant Director of Nursing (ADON), she stated R #1 should be repositioned according to the repositioning clock on R #1's wall, and nursing staff should document at the nursing station each time R #1 was repositioned. I. On 05/16/24 at 12:44 pm during an interview with Nursing Assistant (NA) #1, she stated nursing staff repositioned R #1 according to the reposition clock on R #1's wall, and they were supposed to document when R #1 was repositioned. J. On 05/16/24 at 1:19 pm during an interview with the Regional Nurse Consultant (RNC), she stated she expected the nursing staff to use the repositioning clock as a guide and reposition R #1 in the position according to the clock. The RNC also stated R #1 should be repositioned every two hours, but staff were not required to document when R #1 was repositioned.

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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 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. 41988 Based on record review and interview, the facility failed to effectively manage pain for 1 (R #3) of 1 (R #3) residents reviewed for pain when staff did not provide pain treatment. This deficient practice likely resulted in R #3 experiencing long periods of pain without sufficient relief. The findings are: A. Record review of R #3's face sheet revealed R #3 was admitted to the facility from the hospital on 05/09/24 at approximately 7:00 pm and was discharged home on 05/10/24 at 11:40 am. B. Record review of R #3's hospital discharge orders, dated 05/09/24 at 2:24 pm, revealed a discharge medication order for hydrocodone-acetaminophen tablet (opioid pain medication), 5-325 milligram (mg). One tablet, orally, every eight hours as needed. C. Record review of R #3's physician orders, dated 05/09/24 at 7:15 pm, revealed an order for hydrocodone-acetaminophen, 5-325 mg. Give one tablet by mouth every eight hours as needed for pain. D. Record review of R #3's pain evaluation form, dated 05/09/24 at 11:29 pm, revealed R #3's pain level (measured pain on a scale of 1-10) was a 9 (very severe pain) out of 10 (worst possible pain) and his pain intensity (how strong pain is felt) in the past 24 hours was an 8 (very severe pain) out 10 (worst possible pain). E. Record review of R #3's Treatment Administration Record (TAR), dated 05/09/24, revealed staff did not administer hydrocodone - acetaminophen to R #3 as needed for pain. F. Record review of R #3's physician orders, dated 05/10/24 at 12:21 am, revealed an order for methocarbamol oral tablet (muscle relaxer), 750 mg, methocarbamol. Give one tablet by mouth every six hours as needed for muscle spasms. G. Record review of R #3's nursing progress notes, dated 05/10/24 at 12:41 am, revealed the resident and wife wanted to leave against medical advice (AMA) multiple times related to the resident did not receive pain medication as soon as he got into the facility. H. Record review of R #3's Treatment Administration Record (TAR), dated 05/10/24, revealed staff did not administer hydrocodone - acetaminophen to R #3 as needed for pain. I. Record review of R #3's Medication Administration Record (MAR), dated 05/10/24, revealed staff did not administer methocarbamol to R #3. J. On 05/15/24 at 5:14 pm during an interview with R #3's wife, she stated the facility was not ready for R #3 when he arrived to the facility. She stated R #3 was in a lot of pain after having recent brain surgery, and staff did not give his pain medications as ordered. R #3's wife also stated they left the facility as soon as they could and went to R #3's primary care Physician. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	K. On 05/15/24 at 6:03 pm during an interview with Licensed Vocational Nurse (LVN) #1, she stated she knew R #3 did not receive his pain medication. She stated she offered the resident Tylenol and asked him how the pain was. LVN #1 stated R #3 and his wife wanted to leave against medical advice (AMA) because R #3 was not given hydrocodone. She said they tried to work as fast as they could to get R #3 his hydrocodone pain medication. LVN #1 stated R #3's wife was in distress, because the hospital did not administer R #3's medications before he left. LVN #1 stated staff did not administer hydrocodone to R #3 while he was at the facility because the facility did not have that medication readily available for R #3. L. On 05/16/24 at 1:29 pm during an interview with the Regional Nurse Consultant (RNC), she stated the nursing staff should have used the hydrocodone that was in the facility's medication dispensing cabinet (used for all residents with matching physician orders) for R #3. The RNC stated staff should have administered pain medication to R #3 as ordered, but they did not.

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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** 41988 Based on record review and interview, the facility failed to ensure the medical record was accurate for 2 (R #1 and #2) of 2 (R #1 and #2) residents reviewed, when staff failed to document when a resident's tube feeding solution was changed and when a resident was provided hydration via a tube feed. This deficient practice is likely to result in staff confusion as to the services and treatment provided. The findings are: R #1: A. Record review of R #1's face sheet revealed R #1 was admitted into the facility on [DATE] with the following diagnoses: 1. Stroke (a medical emergency that can cause brain damage and disability). 2. Muscle weakness. 3. Dysphagia (condition with difficulty in swallowing food or liquid). B. Record review of R #1's physician orders, dated 02/09/24, revealed the following: - An order for enteral (involving or passing through the intestine, either naturally via the mouth and esophagus, or through an artificial opening) feed every shift. Jevity 1.5 (specialized nutritional formula) at 55 milliliters (ml) an hour (hr) for 20 hours a day via percutaneous endoscopic gastrostomy tube (PEG; a surgery to place a feeding tube.) Hold four hours daily from 8:00 am to noon. - An order for enteral feed five times a day. Hydration flush 200 ml of water five times a day via PEG. C. Record review of R #1's Nurse Administration Record (NAR), dated 04/01/24 through 04/30/24, revealed the following: - Staff documented they administered Jevity every shift three times out of 60 opportunities. - Staff documented they administered the hydration flush five times out 150 opportunities. D. Record review of R #1's NAR, dated 05/01/24 through 05/16/24, revealed the following: - Staff documented they administered Jevity every shift 12 times out of 32 opportunities. - Staff documented they administered the hydration flush 25 times out of 80 opportunities. E. On 05/16/24 at 10:23 am during an interview with Licensed Practical Nurse (LPN) #1, she stated staff should document tube feeding and hydration via PEG in the NAR each time staff administered them. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	F. On 05/16/24 at 11:29 am during an interview with Registered Nurse (RN) #1, she stated staff should document tube feeding and hydration via PEG in the NAR each time staff administered them. G. On 05/16/24 at 1:25 pm during an interview with the Regional Nurse Consultant (RNC), she stated staff should document tube feeding and hydration via PEG in the NAR. The RNC stated staff did not document R #1's tube feeding and hydration in the NAR. R #2: H. Record review of R #2's face sheet revealed R #2 was admitted into the facility on [DATE] with the following diagnoses: 1. Acute respiratory failure with hypoxia (below-normal level of oxygen in your blood). 2. Gastrostomy status (artificial opening to stomach). 3. Dysphagia. I. Record review of R #2's physician orders, dated 04/26/24, revealed the following: - An order for enteral feed five times a day. Glucerna 1.5 (meal replacement solution) at 250 ml five times a day. - An order for enteral feed six times a day. 150 ml water flushes six times a day. J. Record review of R #2's Medication Administration Record (MAR) dated 05/01/24 through 05/16/24 revealed the following: - Staff documented they administered Glucerna five times a day 71 times out of 80 opportunities. - Staff documented they administered water flushes six times a day 36 times out of 96 opportunities. K. On 05/16/24 at 1:26 pm during an interview, the RNC stated staff should have documented R #2's tube feeding and hydration via tube feeding in the MAR each time it was performed, but they did not.