

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 325066	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/23/2025
NAME OF PROVIDER OR SUPPLIER Bloomfield Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 803 Hacienda Lane Bloomfield, NM 87413	
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 0760</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Ensure that residents are free from significant medication errors.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40671</p> <p>Based on record review and interview, the facility failed to ensure residents received treatment and care in accordance with professional standards of practice for 1 (R #5) of 5 (R #'s 1, 2, 3, 4 and 5) residents when they failed to administer anti-seizure medication (medication used to prevent or stop seizures [sudden burst of electrical activity in the brain]) as ordered. This deficient practice likely resulted in the resident experiencing seizures requiring hospitalization . The findings are:</p> <p>A. Record review of R #5's face sheet revealed an admitted [DATE] and included a diagnosis of epilepsy (seizure disorder).</p> <p>B. Record review of Prepare to Admit document dated 11/20/24 for R #5 revealed that R #5's current medications included Lacosamide (medication used to prevent or treat seizures) 200 milligrams (mg).</p> <p>C. Record review of Minimum Data Set (MDS - federally mandated assessment instrument completed by facility staff) dated 12/04/24 for R #5 revealed the following:</p> <ul style="list-style-type: none"> - Section I - Active Diagnoses: Seizure Disorder or Epilepsy. - Section N - Medications: Anticonvulsant (medication used to prevent and manage seizures) was included. <p>D. Record review of Care Plan dated 11/25/24 for R #5 revealed, Focus: Risk for seizure activity related to diagnosis of epilepsy. Goal: There will be no complications from seizure activity over the next ninety days. Interventions . 4) Medicate as ordered assessing the effectiveness and for any adverse effects.</p> <p>E. Record review of physicians admission medication orders for R #5 included the following order:</p> <ul style="list-style-type: none"> - Lacosamide oral tablet, 200 mg. Give 200 mg orally every 12 hours for epilepsy. Start date: 01/16/24. [no end date] <p>F. Record review of medication administration record (MAR), dated November 1 through 30, 2024 for R #5 revealed no documentation that R #5 received Lacosamide Oral Tablet 200 mg from 11/21/24 through 11/30/24.</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
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<p>F 0760</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>G. Record review of the Facility Hospital Transfer form dated 11/25/24 for R #5 revealed that he was transferred to the hospital due to seizures.</p> <p>H. Record review of the hospital discharge paperwork dated 11/25/24 for R #5 revealed that R #5 was admitted to the hospital for seizure activity. Documentation confirmed that the nursing facility did not have lacosamide on formulary and therefore R #5 had not received this medication over the past four days. Documentation also revealed R #5 was noted to have generalized tonic-clonic seizures (type of seizure that causes loss of consciousness and violent muscle contractions) this afternoon; when emergency medical services (EMS) arrived, R #5 was actively seizing. Per the hospital H&P revealed his [R #5] seizures had been stable over the course of the last year.</p> <p>I. On 04/03/25 at 3:53 pm during an interview with the Director of Nursing (DON), the Administrator (ADM), and Nurse Educator/Unit Manager (NE/UM) revealed the following:</p> <p>DON stated that R #5 arrived in the evening on 11/21/24 and all his medications were received except for the seizure medication; R #5 had several seizures in a row and was sent out to the hospital. DON stated that no one was aware that the seizure medication had not come in until R #5 was sent to the hospital. DON also stated that the nurse on duty was supposed to call and follow up with the pharmacy. NE/UM stated that R #5 was transferred from another facility and the prescription was not sent to the new facility. She stated that R #5's insurance was not going to pay for the medication because the prior facility had already received the prescription. She stated that they contacted the prior facility and requested that the facility either return the medication to the pharmacy or send it to this facility. DON stated that the nurse on duty is supposed to contact the physician to reconcile the resident's admission medications to make sure the physician agrees with the medications. He stated that the order for lacosamide was listed on the medication list but was not on the hard copies that arrived with the resident.</p> <p>J. On 04/03/25 at 4:14 pm during an interview, the Nurse Practitioner (NP) confirmed that she reconciled/verified the admission medications, for R #5, with Registered Nurse (RN) #1 which included the orders for Lacosamide. The NP confirmed that she was not aware that R #5 was not receiving this medication until he was sent to the hospital on 11/25/24.</p> <p>K. On 04/03/25 at 4:31 pm during an interview, RN #2 stated that when she reached out to the the pharmacy regarding R #5's Lacosamide she was told that the medication would be delivered to the facility by the evening on 11/22/24. The facility was later informed by the pharmacy that they could not fill the prescription because it had been filled by the previous facility from which R #5 transferred. The facility reached out to the prior facility requesting that the medication be sent to them or returned to the pharmacy to which the prior facility refused.</p> <p>Based on record reviews and interviews, an Immediate Jeopardy (IJ) was identified. The facility administrator was notified on 04/03/25 at 5:45 pm.</p> <p>The facility took corrective action by providing an acceptable Plan of Removal (POR). The Plan of Removal was approved on 04/04/25 at 12:15 pm.</p> <p>Plan of removal:</p> <p>(continued on next page)</p>		

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<p>F 0760</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>All residents have the potential to be affected by this alleged deficient practice. The following identification/corrections will be completed by 04/03/25.</p> <ul style="list-style-type: none"> - Audit all residents with a diagnosis of seizures to ensure medication therapy is in place as ordered. - A 14 day look back audit of recent admissions to ensure accurate medication reconciliation, review and continuation of medications and treatments. - All licensed staff education to include medication transcription/medication reconciliation upon admission with documentation in the residents chart and steps to follow for medication availability with an emphasis on: validating with the pharmacy on arrival time, pulling from Ekit (emergency kit - contains a small quantity of medications that can be dispensed when pharmacy services are not available) if available, notification of provider for additional orders or medication adjustments, requesting medications from backup pharmacy if needed. - DON/Designee during morning clinical meetings, medication reconciliation audits occur for all new admissions and medication order changes. - DON/Designee to review medications not available during morning clinical meetings. - Nurse Practice Educator/Designee will begin education on 04/03/2025 and continue until all licensed nursing staff have been educated prior to their next shift. Any licensed staff member on leave of absence (FMLA- family medical leave act), vacation, or PRN (as needed) staff will be re-educated prior to returning to duty. New hires will be educated on this process upon hire. - The Director of Nursing/designee will audit 5 random residents 3 x (times) week to ensure all medications reconciliation have occurred. - DON and/or designee will bring results of audits to QAPI (quality assurance and performance improvement) committee for further recommendations based on tracking and trending presented monthly for the next 2 months or until ongoing compliance is achieved. The QAPI committee is overseen by the Administrator. <p>Implementation of the POR was verified onsite on 04/04/25 by record reviews, and staff interviews. Scope and Severity was reduced to Level 2, D.</p> <p>Implementation was verified through:</p> <p>Record review of the facility's new admissions audit from 03/21/25 through 04/04/25 to ensure accurate medication reconciliation, review and continuation of medications and treatments.</p> <p>Record review of the facility's audit of all current residents with a diagnosis of seizures to ensure medication therapy was in place as ordered.</p> <p>(continued on next page)</p>		

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<p>F 0760</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Record review of staff signature sheets for the education provided to the licensed staff, to include medication transcription/medication reconciliation upon admission with documentation in the residents' chart and steps to follow for medication availability with an emphasis on: validating with the pharmacy on arrival time, pulling from Ekit if available, notification of provider for additional orders or medication adjustments, requesting medications from backup pharmacy if needed.</p> <p>Interviews of two nurses verified the in-service they received on 04/03/25 and 04/04/25 included medication transcription/medication reconciliation upon admission with documentation in the residents' chart and steps to follow for medication availability with an emphasis on: validating with the pharmacy on arrival time, pulling from Ekit if available, notification of provider for additional orders or medication adjustments, requesting medications from backup pharmacy if needed.</p> <p>Interview with the Administrator and DON regarding POR, audits new admissions audit from 03/21/25 through 04/04/25 to ensure accurate medication reconciliation, review and continuation of medications and treatments; audit of all current residents with a diagnosis of seizures to ensure medication therapy was in place as ordered; and education provided to the licensed staff, to include medication transcription/medication reconciliation upon admission with documentation in the residents' chart and steps to follow for medication availability with an emphasis on: validating with the pharmacy on arrival time, pulling from Ekit if available, notification of provider for additional orders or medication adjustments, requesting medications from backup pharmacy if needed.</p>		